Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173; PL 2013 ch. 368, Part A §A-34
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. III Section 45**, Hospital Services
Filing number:	**2014-017**
Effective date:	2/13/2014
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

On November 15, 2013, the Department adopted an emergency rule which increased the MaineCare hospital supplemental pool for Acute Care Non-Critical Access hospitals, hospitals reclassified to a wage area outside Maine and rehabilitation hospitals, to $65.321 million, because the Legislature appropriated an additional $10.472 million for this purpose. P.L. 2013, ch. 368, Part A, §A-34. This rule-making makes the changes in the November 15, 2013 emergency rule permanent. The State Plan Amendment for this change was submitted in the 4th quarter of 2013, and is awaiting approval.

Basis statement:

This rule-making permanently adopts changes made on an emergency basis, effective November 15, 2013, to implement provisions in P.L. 2013, ch. 368, Part A, §A-34. Specifically, this rule-making increases the MaineCare hospital supplemental pool to $65.321 million, because the Legislature appropriated an additional $10.472 million. The State Plan Amendment for this change was submitted in the fourth quarter of 2013, and is awaiting approval.

The Department estimates that the hospital pool rule-making will cost an additional $10.472 million per state fiscal year; the MaineCare supplemental pool total of $65.321 million has been clarified to include $3.2 million of reimbursement that had previously been allocated by outpatient costs, prior to the APC reimbursement methodology.

This rule-making will not impose any costs on municipal or county governments, or have any adverse impact on small businesses employing twenty or fewer employees.

Fiscal impact of rule:

Pursuant to P.L. 2013, ch. 368, Part A, §A-34, and this rule-making will cost an additional $10.472 million per state fiscal year. Additionally, the MaineCare supplemental pool total of $65.321 million has been clarified to include $3.2 million of reimbursement that had previously been allocated by outpatient costs, prior to the APC reimbursement methodology.

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Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173; 5 MRSA §8054; Resolve 2013 ch. 72
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. III Section 67**, Principles of Reimbursement for Nursing Facilities
Filing number:	**2014-026**
Effective date:	2/28/2014
Type of rule:	Routine Technical
Emergency rule:	Yes

Principal reason or purpose for rule:

In this emergency rule-making, the Department adopts the changes required by Resolve 2013 ch. 72, to clarity the timeframe during which nursing facilities must demonstrate their compliance with the October 1, 2011, 2% Cost-Of-Living Adjustment (COLA) for front line staff. If CMS approves, the following applies for the 2%, October 2011, COLA that the Department gave to nursing facilities: nursing facilities must demonstrate, to the satisfaction of the Department, a 2% increase in the average wage and benefit rate per hour for front line employees for their first fiscal years ending after July 1, 2013, from the average wage and benefit rate per hour for front line employees that was in effect for their fiscal years ending 2008. If the nursing facilities cannot demonstrate that 2% increase to the satisfaction of the Department, then the Department will recoup, at time of audit, the difference between what the average wage and benefit rate per hour for front line employees for the first fiscal years ending after July 1, 2013 should have been if it had been increased by 2% from what it was.

Basis statement:

In this emergency rule-making, the Department adopts the changes required by Resolve 2013 ch. 72, to clarify the timeframe during which nursing facilities must demonstrate their compliance with the October 1, 2011, 2% Cost-Of-Living Adjustment (COLA) for front line staff. If CMS approves, the following applies for the 2%, October 2011, COLA that the Department gave to nursing facilities: nursing facilities must demonstrate, to the satisfaction of the Department, a 2% increase in the average wage and benefit rate per hour for front line employees for their first fiscal years ending after July 1, 2013, from the average wage and benefit rate per hour for front line employees that was in effect for their fiscal years ending 2008. If the nursing facilities cannot demonstrate that 2% increase to the satisfaction of the Department, then the Department will recoup, at time of audit, the difference between what the average wage and benefit rate per hour for front line employees for the first fiscal years ending after July 1, 2013 should have been if it had been increased by 2% from what it was.

Fiscal impact of rule:

This rule is not expected to have any fiscal impact; the funds for the COLA have already been paid to providers.

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Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II Section 13**, Targeted Case Management Services
Filing number:	**2014-041**
Effective date:	3/20/2014
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule seeks to permanently adopt the emergency rule effective December 20, 2013, that updates the *Targeted Case Management (TCM)* policy to include the Child and Adolescent Needs and Strengths (CANS) assessment as an approved TCM eligibility tool. The Department will no longer fund the Child and Adolescent Functional Assessment Scales (CAFAS) as of January 31, 2014, and must have the CANS in place to assure that providers who cannot self-fund the CAFAS have an approved tool to evaluate members for TCM eligibility.

Basis statement:

This rule permanently adopts the emergency rule effective December 20, 2013, that updates the Section 13, *Targeted Case Management (TCM)* policy to include the Child and Adolescent Needs and Strengths (CANS) assessment as an approved TCM eligibility tool for Children with Behavioral Health Disorders and Children with Developmental Disabilities/Intellectual Disabilities. The CANS assessment is a multipurpose tool that assesses the needs and strengths of children and adolescents with mental illness, developmental disabilities/intellectual disabilities, and autism spectrum disorders. This tool is clinically current, is technologically superior to comparable tools, is designed to directly link the assessment to the service planning process, is efficient to administer and is economical.

The use of the CANS assessment tool has no fiscal impact on the Office of MaineCare Services.

This rule-making will not impose any costs on municipal or county governments, or on small businesses employing fewer than twenty employees.

Fiscal impact of rule:

The Department anticipates this policy change will result in an estimated savings of $406,161.42 to the Office of Child and Family Services in SFY'14 and will be cost neutral to MaineCare Services.

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Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173; 42 USC §1396w-4
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II & III Section 92**, Behavioral Health Home Services
Filing number:	**2014-059**
Effective date:	4/1/2014
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This proposed rule-making seeks to create Behavioral Health Homes, effective April 1, 2014, which will provide comprehensive system of care coordination for members with Serious Emotional Disorders (SED), and Serious and Persistent Mental Illness (SPMI). Members eligible for Section 92 services may also be eligible for services under Section 13 (Targeted Case Management), Section 17 (Community Integration Services) and/or Section 91 (Health Home Services); such members may not receive those services at the same time that they receive Section 92 services, and must choose among the different types of services for which they are eligible.

Section 92 services shall be provided to eligible members by a Behavioral Health Home Organization (BHHO) that partners with one or more Health Home Practices (HHPs). BHHOs and HHPs shall integrate and coordinate all primary, acute, behavioral health and long term services and supports for eligible members. BHHOs shall develop and implement a comprehensive Plan of Care for each member. Section 92 services are expected to result in improved physical and behavioral health outcomes for members, reduced hospital admissions and emergency room use, better transitional care, improved communication between health care providers, and the increased use of preventive services, community supports, and self-management tools.

Section 92 Behavioral Health Homes are implemented pursuant to section 2703 of the *Affordable Care Act*, 42 U.S.C. § 1396w-4. The Department is seeking approval of a State Plan Amendment from the Centers for Medicare and Medicaid Services (CMS). Section 2703 provides an enhanced federal matching rate of 90% for the first eight (8) quarters following the effective date of the program.

Basis statement:

This rule-making creates Behavioral Health Homes, effective April 1, 2014, which will provide comprehensive system of care coordination for members with Serious Emotional Disorders (SED), and Serious and Persistent Mental Illness (SPMI). Members eligible for Section 92 services may also be eligible for services under Section 13 (Targeted Case Management), Section 17 (Community Integration Services) and/or Section 91 (Health Home Services); such members may not receive those services at the same time that they receive Section 92 services, and must choose among the different types of services for which they are eligible.

Section 92 services shall be provided to eligible members by a Behavioral Health Home Organization (BHHO) that partners with one or more Health Home Practices (HHPs). BHHOs and HHPs shall integrate and coordinate all primary, acute, behavioral health and long term services and supports for eligible members. BHHOs shall develop and implement a comprehensive Plan of Care for each member. Section 92 services are expected to result in improved physical and behavioral health outcomes for members, reduced hospital admissions and emergency room use, better transitional care, improved communication between health

care providers, and the increased use of preventive services, community supports, and self-management tools.

Section 92 Behavioral Health Homes are implemented pursuant to §2703 of the *Affordable Care Act*, 42 U.S.C. §1396w-4. The Department is seeking approval of a State Plan Amendment from the Centers for Medicare and Medicaid Services. Section 2703 provides an enhanced federal matching rate of90% for the first eight (8) quarters following the effective date of the program.

The rule has been amended to reflect public comments received, including the following:

- 92.01 Definitions:
    - 92.01-3 Electronic Health Record (EHR): Additional language has been added to this section to clarify the EHR definition.
    - 92.01-7 Plan of Care: deleted language that required all clinical data to be in the Plan of Care.
- 92.02-1 Provider Requirements (BHHO):
    - Clarified the role of the Psychiatric Consultant
    - Added additional language regarding the type of nurse that can provide the service
    - Added language that permitted the use of Licensed Master Social Worker Conditional II licensure
    - Amended Certified Intentional Peer Support Specialist language to clarify certification requirements
    - Added language to clarify that an individual who provides peer support services for children will be called a “Family or Youth Support Specialist,” rather than a CIPSS, and added language clarifying such individuals’ certification requirements
    - Amended language regarding the role of the HH Coordinator to specify that the HH Coordinator “supports and encourages”
    - Removed language regarding “SPMI member”
    - Added Physician’s Assistant to list of professionals that can serve as Medical Consultant
    - Clarified that the Medical Consultant role may be pro-rated
    - Amended language regarding co-occurring capability
    - Amended language to align with/reference licensing standards
    - Specified that the HHP and BHHO may have an executed contract or a Memorandum of Agreement (MOA), and provided detail regarding the required contents of the contract or MOA
    - Deleted language requiring that EHRs be used to share information
    - Deleted language requiring that BHHO protocols with hospitals must require prompt notification to the BHHO of a member’s admission and discharge
    - Clarified language regarding team-based approach to care
    - Clarified language on enhanced access
    - Included language on recovery
    - Deleted language that BHHO would be held accountable for savings resulting from reductions in wasteful spending
    - Clarified that member and family participation in leadership and/or advisory activities includes, but is not limited to, serving on agency’s Board of Directors, involvement in internal advisory committees that solicit and support the engagement of consumers and families in identifying needs and solutions, etc.

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- 92.02-2 Provider Requirements (HHP):
  - Deleted language requiring that EHRs be used to share information
  - Specified that the HHP and BHHO may have an executed contract or a Memorandum of Agreement (MOA), and provided detail regarding the required contents of the contract or MOA
  - Deleted language requiring that HHP protocols with hospitals must require prompt notification to the HHP of a member's admission and discharge
  - Clarified language on site assessment
  - Clarified that open access scheduling means that the organization leaves some percentage of its appointment hours open for same-day/next day appointments
  - Replaced the term "behavioralist" with a "behavioral health professional"
- 92.03 Member Eligibility
  - Made changes to this section to reflect that information on the member shall be stored only in the member's record and not the member's record and the Plan of Care
  - Updated (*Diagnostic and Statistical Manual of Mental Disorders*) DSM title
- 92.04 Policies And Procedures For Member Identification And Enrollment
  - Clarified that members will be identified based on current prior authorizations and not via a 12-month look back period
  - Clarified that the time period to identify an HHP is six months and not 180 days
  - Amended to use "enrollment" and not "assignment" throughout
  - Amended to refer to "members' clinical documentation," as opposed to "medical documentation"
- 92.05 Covered Services
  - Amended that BHH services may be delivered "in any community location where confidentiality can be maintained" as opposed to "in any appropriate location"
  - Amended to include additional language about member strengths
  - Deleted requirement that all clinical data would need to be contained in the member's Plan of Care
  - Amended to reflect documentation required in member record and not Plan of Care
  - Clarified the meaning of "crisis provider"
  - Clarified that the BHHO shall facilitate access to psychiatric services, not provide access
  - Clarified that the BHHO shall facilitate access to referral services, not ensure successful referral
  - Added language – consistent with Section 91 – to clarify that as part of care management, HHPs shall conduct certain screenings and assessments for all of their assigned BHH members
- 92.06 Non-Covered Services and Limitations
  - Deleted language that referenced direct delivery of underlying services
  - Amended language to reflect that the member may only have one BHHP Team
- 92.07 Reporting Requirements
  - Deleted the list of quality measures
- 92.08 Documentation and Confidentiality
  - Amended language to reference current licensing standards

  - Deleted 92.08 (B) "Record Retention," because it is redundant with the requirements of *MaineCare Benefit Manual* Chapter 1, Section 1
  - Deleted "The disclosure of information regarding members receiving services herein is strictly limited to purposes directly connected with the administration of the MaineCare program" because it would preclude any other sharing of information permitted by state and federal law
- 92.09 Minimum Requirements for Reimbursement
  - Amended language to reflect provider requirement to submit cost and utilization reports upon request by the Department, in a format determined by the Department

The Department estimates that the General Fund impact will be a savings of $1,409,281 in SFY 2014 and $5,750,453 in SFY 2015.

This rule-making will not impose any costs on municipal or county governments, or on small businesses employing fewer than twenty employees.

Fiscal impact of rule:

The Department estimates that the General Fund impact will be savings of $1,409,281 in SFY 2014 and $5,750,453 in SFY 2015.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. III Section 21**, Allowances for Home and Community Benefits for Adults with Intellectual Disabilities or Autistic Disorder
Filing number:	**2014-063**
Effective date:	5/2/2014
Type of rule:	Major substantive
Emergency rule:	No

Principal reason or purpose for rule:

The Department of Health and Human Services (DHHS) is proposing two substantive changes to Ch. III Section 21 of the *MaineCare Benefits Manual*. First, the Department is proposing to remove the procedure code for Transportation Services, in order to comply with the concurrent operation of a new 1915(b) Non-Emergency Transportation Waiver. These proposed changes to Section 21 will be effective only upon implementation of the 1915(b) Non-Emergency Transportation Waiver. Going forward, members who receive services under the Section 21 waiver will be provided nonemergency transportation through Section 113 of the *MaineCare Benefits Manual*. Under risk-based contractual agreements, the Department will contract with Broker(s) to establish, manage, authorize, coordinate and reimburse the provision of non-emergency transportation services for eligible MaineCare members. The Broker(s) will be responsible for establishing a network of non-emergency transportation drivers to deliver non-emergency transportation services to eligible members who live in their assigned region.

Second, the Department is proposing to add a HCPCS procedure code for Behavioral Consultation, G9007 HI. The proposed reimbursement rate for Behavioral Consultation is $14.85 per fifteen minute unit. The Centers for Medicare and Medicaid Services have approved the addition of Board Certified Behavior Analyst to provide Behavioral Consultation. Lastly, the Department is also proposing to update several internet addresses that appear through Ch. III Section 21.

Basis statement:

This adopted rule provides MaineCare members, receiving Section 21, Allowances for Home and Community Benefits for Adults with Intellectual Disabilities or Autistic Disorder Services access to transportation for their Section 21 services through the same Section 113 Transportation Broker that provides the transportation for all other MaineCare medical needs and appointments. The April 23, 2013, Centers for Medicare & Medicaid Services (CMS) approval of the Maine Non-Emergency Transportation waiver (*MaineCare Benefits Manual*, Section 113, Non-Emergency Transportation (NET) Services) expressly required that all of the Maine 1915(c) home and community-based services (HCBS) waivers use the Section 113 waiver for all transportation needs for members.

On October 2, 2012, CMS approved an amendment to the Section 21 waiver to waive the Section 1902(a) (32) freedom of choice provision, limiting the Section 21 member's choice of provider of transportation services, in order that this waiver will be consistent with the requirements of the Section 113 waiver.

Additionally, the Department is adding a HCPCS procedure code for Behavioral Consultation. G9007 III will be $ 14.85 per fifteen-minute unit. The Department added III to the modifier table based on comments.

Fiscal impact of rule:

The Department anticipates that this rule-making will be cost neutral.

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Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. III Section 29**, Allowances for Support Services for Adults with Intellectual Disabilities or Autistic Disorder
Filing number:	**2014-064**
Effective date:	5/2/2014
Type of rule:	Major substantive
Emergency rule:	No

Principal reason or purpose for rule:

The Department of Health and Human Services (DHHS) is amending Ch. III, Section 29 of the *MaineCare Benefits Manual*, by removing the procedure code for Transportation Services. This change is necessary to comply with the concurrent operation of a new 1915(b) Non-Emergency Transportation Waiver. These proposed changes to Section 29 will be effective only upon implementation of the 1915(b) Non-Emergency Transportation Waiver. Going forward, members who receive services under the Section 29 waiver will be provided non-emergency transportation through Section 113 of the *MaineCare Benefits Manual*. Under risk-based contractual agreements, the Department will contract with Broker(s) to establish, manage, authorize, coordinate and reimburse the provision of non-emergency transportation services for eligible MaineCare members. The Broker(s) will be responsible for establishing a network of nonemergency transportation drivers to deliver non-emergency transportation services to eligible members who live in their assigned region.

Basis statement:

This adopted rule provides Section 29 MaineCare members access to transportation for their Section 21 services through the same Section 113 Transportation Broker that provides them transportation for all other MaineCare medical needs and appointments. The April 23, 2013, Centers for Medicare & Medicaid Services (CMS) approval of the Maine Non-Emergency Transportation waiver (*MaineCare Benefits Manual*, Section 113) expressly required that all of the Maine 1915(c) home and community-based services (HCBS) waivers use the Section 113 waiver for all transportation needs for members.

On October 2, 2012, CMS approved an amendment to Section 29 waiver to waive the Section 1902(a) (32) freedom of choice provision, limiting the Section 29 member's choice of provider of transportation services, in order that this waiver will be consistent with the requirements of the Section 113 waiver.

This rule change is not anticipated to have any adverse impact on small businesses or impose any additional costs on municipalities or counties.

Fiscal impact of rule:

The Department anticipates that this rule-making will be cost neutral.

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Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. III Section 32**, Allowances for Waiver Services for Children with Intellectual Disabilities or Pervasive Developmental Disorders
Filing number:	**2014-065**
Effective date:	5/2/2014
Type of rule:	Major substantive
Emergency rule:	No

Principal reason or purpose for rule:

This rule is to permit MaineCare members to access transportation services along with their 1915(c) Home and Community Benefits. The Department is adopting changes to this rule to provide services for members with Intellectual Disabilities and Autistic Disorders concurrently with the operation of a 1915(b) Non-Emergency Transportation Waiver. These changes to Section 32 will be effective only upon implementation of the 1915(b) Non-Emergency Transportation Waiver. Members who receive services under this policy will be provided Non-Emergency Transportation under Section 113 of the *MaineCare Benefits Manual*. The Department will contract with Broker(s) to establish, manage, authorize, coordinate and reimburse the provision of Non-Emergency Transportation services for eligible MaineCare members. The Broker(s) will be responsible for establishing a network of Non-Emergency Transportation drivers to deliver Non-Emergency Transportation services to eligible members who live in their assigned region.

Basis statement:

This rule adopts changes in the reimbursement of services to members with Intellectual Disabilities and Autistic Disorders by deleting the reimbursement of transportation services, since transportation services are provided under the *MaineCare Benefits Manual* Section 113 Non-Emergency Transportation waiver transportation services.

On October 2, 2012, CMS approved an amendment to Section 32 waiver to waive the Section 1902(a)(32) freedom of choice provision, to limit the Section 32 Member's choice of provider of transportation services, in order that this waiver will be consistent with the requirements of the Section 113 waiver. An emergency rule took effect 8/1/13; this is the final adoption of a permanent rule.

Fiscal impact of rule:

The Department anticipates that this rule-making will be cost neutral.

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Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173; Resolve 2013 ch. 72
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. III Section 67**, Principles of Reimbursement for Nursing Facilities
Filing number:	**2014-101**
Effective date:	5/29/2014
Type of rule:	Routine technical
Emergency rule:	No

Principal reason or purpose for rule:

In this rule-making, the Department proposes the changes required by Resolve 2013 ch. 72, to clarify the timeframe during which nursing facilities must demonstrate their compliance with the October 1, 2011, 2% Cost-Of-Living Adjustment (COLA) for front line staff. If CMS approves, the following applies for the 2%, October 2011, COLA that the Department gave to nursing facilities: nursing facilities must demonstrate, to the satisfaction of the Department, a 2% increase in the average wage and benefit rate per hour for front line employees for their first fiscal years ending after July 1, 2013, from the average wage and benefit rate per hour for front line employees that was in effect for their fiscal years ending 2008. If the nursing facilities cannot demonstrate that 2% increase to the satisfaction of the Department, then the Department will recoup, at time of audit, the difference between what the average wage and benefit rate per hour for front line employees for the first fiscal years ending after July 1, 2013 should have been if it had been increased by 2% from what it was.

This rule-making also:

1. Removes the word "Care" from 'Routine Care Cost Component" on pg. 3 of Section 67.
2. MIHMS went live on 9/1/2010. Removes - from Section 41.2.3(D), old language regarding how sanctions were calculated in the time leading up to MIHMS implementation and language referring to MIHMS implementation in the future tense.
3. MIHMS went live on 9/1/2010. Removes - from Section 80.3.4, old language regarding how the "Direct Care Component" was calculated in the time leading up to MIHMS implementation and language referring to MHIMS implementation in the future tense.
4. Changes 'Brain Injury' to ‘Acquired Brain Injury’ and 'BI' to 'ABI' on pages 71 and 72 to use the same definitions set forth in 22 MRS §3086 and to be consistent with terminology utilized in Sec. 67, Ch. II.

Basis statement:

The Department has determined that the adoption of this rule is necessary to permanently implement provisions of Resolve 2013 ch. 72. As mandated by the Legislature, the Department is implementing the changes needed to allow for cost of living adjustments for certain nursing facilities. The Department is seeking approval from the federal Centers for Medicare and Medicaid Services for a state plan amendment for this change.

The Department estimates that these reimbursement changes will be budget neutral.

Fiscal impact of rule:

This rule is not expected to have any fiscal impact; the funds for the COLA have already been paid to providers.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. III Section 97**, Private Non-Medical Institution Services
Filing number:	**2014-113**
Effective date:	6/30/2014
Type of rule:	Major substantive
Emergency rule:	No

Principal reason or purpose for rule:

This rule adopts the changes made by an emergency major substantive rule, effective June 26, 2013, which eliminated the reimbursement rate for *Private Non-Medical Institution Services* (PNMI), Appendix D ("Child Care Facilities"), Model 3 ("Intensive Mental Health Services for Infants and/or Toddlers"), because those services are being eliminated through separate rule-making for Ch. II Section 97. For several years, the Department has worked with the Centers for Medicare and Medicaid (CMS), as well as various MaineCare stakeholders, on CMS' compliance concerns in regard to PNMI services, found in Section 97 of the *MaineCare Benefits Manual*. CMS requires, and the Department is in the process of developing, a comprehensive new model for providing certain services currently delivered through Section 97. Eliminating the PNMI Appendix D, Model 3 service (and reimbursement rate) is the first step in this comprehensive restructuring of the PNMI services.

Basis statement:

This rule will finally adopt the changes made by an emergency rule, effective June 26, 2013, which eliminates the reimbursement rate for *Private Non-Medical Institution (PNMI) Services*, Appendix D ("Child Care Facilities"), Model 3 ("Intensive Mental Health Services for Infants and/or Toddlers"). In a separate rule-making, the Department permanently adopted the elimination of PNMI, Appendix D, Model 3, effective October 11, 2013. Although eligible infants and toddlers no longer have access to PNMI, Appendix D, Model 3, they remain eligible for medically necessary Behavioral Health Services through Ch. II Section 65, *Behavioral Health Services*.

For several years, the Department has worked with the Centers for Medicare and Medicaid (CMS), as well as various MaineCare stakeholders, on CMS' compliance concerns in regard to PNMI services, found in Section 97 of the *MaineCare Benefits Manual*. CMS requires, and the Department is in the process of developing, a comprehensive new model for providing certain services currently delivered through Section 97. Eliminating the PNMI Appendix D, Model 3 service (and reimbursement rate) is the first step in this comprehensive restructuring of the PNMI services.

The Department has kept stakeholders apprised of these changes to PNMI services. On or about June 4, 2013, the Department sent notice, attached hereto, to all MaineCare members to inform them of this change to their MaineCare PNMI benefits. In addition, in a memorandum dated January 9, 2013, DHHS Commissioner Mayhew notified PNMI providers and other interested parties that the infant and/or toddler intensive mental health PNMI services would be eliminated, effective in July 2013.

Additionally, the rule corrects prior rules and amends the reimbursement rates for PNMI, Appendix D, "Child Care Facilities" (Child Mental Health Level I, Child Mental Health Level II, Mental Retardation and Pervasive Developmental Disorder Level I, Mental Retardation and Pervasive Developmental Disorder Level II, Crisis Residential, Treatment Foster Care, and

Treatment Foster Care-Multidimensional) to agree with the correct rates configured in the MaineCare claims system. The rates in the prior rules were lower than the correct rates.

Fiscal impact of rule:

The Department anticipates this rule-making will save approximately $3,450,298.85 for the elimination of Intensive Infant Mental Health Services and will potentially cost the Department approximately $189,109.00 for the Child Care Facilities reimbursement rate correction for a total savings of $3,261,189.85 in SFY14.

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Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II & III Section 20**, Home and Community Based Services for Adults with Other Related Conditions
Filing number:	**2014-124**
Effective date:	7/1/2014
Type of rule:	Routine technical
Emergency rule:	No

Principal reason or purpose for rule:

There are some technical changes that the Department is proposing. The Department is proposing to clarify the definitions of Priority I and Priority 2 members. The Department is proposing to clarify that the rate for Community Support includes the cost of transportation and is a component of the rate paid for the service. A clarification is needed to Home Support to state a member may have some 1:1 direct care and it must be specified in the care plan.

The Department is also proposing to add clarifying language to Assistive Technology and Communication Aids to state: "Each system or device will be revised based on medical necessity, efficiency and meets compatibility with safety needs."

Additionally, the Department has submitted a waiver amendment to CMS and is proposing changes to the policy to coincide with CMS approval. The following changes are dependent on CMS approval.

The Department is proposing to increase the limit of Community Support and Work Support from 64 units each to allowing the member a combination of 128 units of either service. The maximum weekly allowance for Community Support is 128 units, for an annual total of 6,656 units. The maximum weekly allowance for Work Support Services is 128 units, for an annual total of 6,656 units. When members use a combination of both services, there is an annual limit of 6,656 units on the total combined expenditures for the services.

The Department is proposing a new limit of 64 units per day from 44 per day of Home Support Remote Support and 64 units per day from 44 per day of Home Support-Quarter hour.

The Department is proposing to clarify Remote Support-Interactive Support and Remote Support Monitor only as two separate components of Remote Support and reimbursed separately.

The Department is proposing to change the limit of Communication Aids from $2,000.00 to $6,000.00 per year. A Licensed Speech Language Pathologist (SLP) is being proposed to be added as a qualified provider of Communication Aids. This proposes that Care Coordination limits to change to 400 from 144 units every year, instead of just the first year.

The Department is also proposing to add clarifying language that Consultation is limited to 64 units per each type of consultation annually.

The waiver is being amended to update the effective date, clarify limits and to update the annual coast of an ICF IIID to the current amount of $200,000.00 per member.

Basis statement:

The rules have been amended to make a number of clarifications and technical changes, as follows:

- Clarification of the prioritization categories for members on the waitlist for Section 20 services;

- Clarification that the rate for the Community Support service includes the cost of transportation, i.e., that transportation costs are a component of the rate paid for the service;
- Clarification that a member may receive some 1: 1 direct care under the Home Support service, and that the need for 1: 1 support must be specified in the care plan; and,
- Clarification that Assistive Technology devices and Communication Aids will be reviewed based on medical necessity, efficiency and compatibility with safety needs.

Additionally, the Department made changes to comply with amendments to the Section 20 waiver program that were formerly approved by the Centers for Medicare and Medicaid (CMS) on May 5, 2014. These include the following:

- An increase in the limit for the Community Support and Work Support services from 64 units each to allowing the member a combination of 128 units of either service, subject to an annual limit of 6,656 units on the total combined expenditures for both services;
- An increase in the limit for the Home Support -Remote Support service from 44 units per day to 64 units per day;
- An increase in the limit for the Home Support-Quarter Hour service from 44 units per day to 64 units per day;
- An increase in the limit for Communication Aids from $2,000.00 to $6,000.00 per year;
- An increase in the limit for the Care Coordination service from 144 units to 400 units per year;
- Clarification that the Consultation service is limited to 64 units per each type of consultation annually;
- Clarification that Remote Support-Interactive Support and Remote Support-Monitor are two separate components of Remote Support and are reimbursed separately; and,
- The addition of Licensed Speech Language Pathologists (SLP) as qualified providers of Communication Aids.

Additionally, the Department is making changes to the final rule based on comments. The Department is changing the final rule to allow a Direct Support Professional (DSP) 90 days to complete their DSP and begin work as long as they also have 5 (five) modules from the College of Direct Support (CDS) before being alone with a member. The modules are: 1) Safety at Home and in the Community, 2) Personal Care, 3) Professionalism, 4) Individual Rights and Choice and 5) Maltreatment.

Changes to final rule based on comment received from the Attorney General's office;

20.07-1: The word "revised" has been changed to "reviewed", the word "meets" has been deleted.

20.07-3: The word "meets" has been deleted.

20.07-4 and 20.07-16: When members use a combination of both services, there is a weekly limit of 128 units per week and an annual limit of 6,656 units on the total combined expenditures for the services.

20.07-5: The word "per" has been added.

Fiscal impact of rule:

The Department expects that the implementation of this rule-making will be cost neutral.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173, 3174-RR
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II Section 31**, Federally Qualified Health Center Services
Filing number:	**2014-130**
Effective date:	7/1/2014
Type of rule:	Routine technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule-making seeks to make the following changes: (1) Adds three dental provider types - Independent Practice Dental Hygienists, Dental Externs, and Dental Residents - that are concurrently being proposed in *MaineCare Benefits Manual*, Ch. II Section 25, "Dental Services", and clarifies that dental services rendered in FQHCs must be performed in accordance with Maine Board of Dental Examiners requirements. IPDHs are added effective October 1, 2013, subject to approval by CMS; Dental Externs are added effective September 1, 2011; and Dental Residents are added effective 365 days before the rule's date of adoption. (2) In the tobacco cessation paragraph makes an update to reflect the upcoming national change from ICD-9 to ICD-10.

Basis statement:

This rule-making makes the following changes to Ch. II Section 31, "Federally Qualified Health Center Services":

1. The addition of three dental provider types:
    - **Independent Practice Dental Hygienists** (IPDHs), as required by per P.L. 2011, Chap. 457 "An Act To Include Independent Practice Dental Hygienists in MaineCare."
    - **Dental Externs**. Adding this provider type will increase access to dental services by MaineCare beneficiaries.
    - **Dental Residents**. Adding this provider type will increase access to dental services across the state.

   Dental Externs are added as a MaineCare provider, effective July 1, 2013. The July 1, 2013 effective date for Dental Externs is consistent with the proposed rule, which proposed adding this provider type "effective 365 days before date of adoption". The adopted rule clarifies precisely what the effective date is of this change.
   Dental Residents are added as a MaineCare provider effective July 1, 2013, although the proposed rule added them as a provider type effective September 1, 2011. As a result of comments received, and advice from the Office of the Attorney General, the Department changed the effective date to July 1, 2013. Federal Medicaid law requires state Medicaid agencies like MaineCare to "require [Medicaid] providers to submit all claims no later than 12 months from the date of service." 42 CFR 447.45(d)(*Timely processing of claims*). Accordingly, MaineCare cannot add a provider type retroactively beyond the 12 months, since claims from an earlier period could not legally be processed as MaineCare claims.
2. Tobacco cessation codes were updated to reflect the upcoming national change from ICD-9 to ICD-10. 45 CFR Sec 162.1000 requires covered entities such as the Maine Office of MaineCare Services, to utilize the Medical data code sets as specified in the federal regulation that are valid at the time the health care is provided. As of the

date this rule became effective, CMS, and the Office of MaineCare Services, utilized the International Classification of Diseases, 9th Edition, *Clinical Modification*, (ICD-9-CM), and Volume 3, *Procedures*, (including *The Official ICD-9-CM Guidelines for Coding and Reporting*). CMS has notified states that it intends to switch to the ICD-10 Manual at some time in the future.

3. The Department added a sentence: "Dental services rendered under this policy must be performed in accordance with the Maine Board of Dental Examiners requirements" to clarify that this is a legal requirement.
4. Per Public Law 2014 ch. 444, eliminates the three times per year limit on tobacco counseling and specifies that smoking cessation counseling is exempt from the copayments required by 31.08 (A). This change was not in the proposed rule because the Legislature enacted the change after the rule was proposed. The Department has determined that it is appropriate to include this change in the adopted rule due to the fact that: (1) the changes required by statute should be effective by August 1, 2014 (90 days upon the Legislature's adjournment), and it would not be possible to meet that deadline without including it in this adopted rule; (2) the public had an opportunity to comment on this change during the legislative process; and (3) the changes have a positive impact on both members and providers.

This rule has retroactive application effective dates for adding the three new provider types. The Department is authorized to adopt rules with retroactive application, pursuant to 22 MRSA 42(8), when necessary to conform to the State plan and to maximize federal Medicaid funding, and where there is no adverse financial impact on any MaineCare provider or Member. Here, because there is a positive impact on MaineCare providers and Members, since the Department is adding new provider types, and access to dental services should be improved, the retroactive application of those provider types is appropriate.

Fiscal impact of rule:

The Department estimates that the General Fund impact of adding Dental Externs and Dental Residents to Section 31 is $170,296 in SFY 2013; $226,007 in SFY 2014, and $226,007 in SFY 2015. The Department estimates that the total General Fund impact of adding IPDHs (under Sections 31 and 25 (Dental Services)) is: $99,741 in SFY 2014 ($40,740 of which was appropriated by the Legislature in P.L. 2011 Chap. 457) and $208,981 in SFY 2015 ($54,320 of which was appropriated by the Legislature in P.L. 2011 ch. 457), with an undetermined portion of the impact attributable to FQHCs.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173, 3174-RR
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II & III Section 25**, Dental Services
Filing number:	**2014-131**
Effective date:	7/1/2014
Type of rule:	Routine technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule-making seeks to:

1. Update policy to conform to changes in the American Dental Association's 2014 CDT Dental Procedure Codes (this includes addition, deletion, and renaming of codes, as appropriate).
2. Add Independent Practice Dental Hygienists (IPDHs) as a qualified provider, per P.L. 2011 ch. 457 "An Act to Include Independent Practice Dental Hygienists in MaineCare".
3. Add partial dentures to services reimbursable to denturists, in order to be consistent with changes to Title 32 pursuant to per P.L. 2009 ch. 227 "An Act to Allow Qualified, Licensed Denturists To Practice to the Level of Their Educational Training".
4. Specify that MaineCare will reimburse for procedures performed by dental residents and externs under the supervision of a dentist, in accordance with the rules of the Maine Board of Dental Examiners.
5. Make clerical, technical, and administrative corrections and updates.
6. Lower the rate for intravenous (IV) sedation in order to pay for the addition of IV-sedation as a covered service.
7. Change limitations for a number of specific procedures, including, but not limited to:
   a. changing the limits on the following services from once per six (6) months or twice per year to twice per calendar year, but no more than once every 150 days: prophylaxis, oral evaluations, application of fluoride and fluoride varnish;
   b. changing the limit on panoramic radiographs from "billable with pre-orthodontic visit" to "separately billable without PA once per five (5) years when used in conjunction with any preventative and/or diagnostic service" (to be consistent with an October 2010 policy clarification letter);
   c. adding a new limit that the Department will reimburse for one (1) comprehensive orthodontic treatment per member per lifetime, and the orthodontic retention phase shall not exceed 24 months.

The Department will seek required approval from the Centers for Medicare and Medicaid Services for a State Plan Amendment to add IPDHs as a qualified provider and to add new codes and limits.

Basis statement:

The rule-making makes the following changes: (1) adds three dental provider types: Independent Practice Dental Hygienists (effective October 1, 2013 subject to approval from CMS), Dental Externs (effective July 1, 2013), and Dental Residents (effective July 1, 2013); (2) eliminates the limit on tobacco counseling; (3) adds partial dentures to services reimbursable to denturists; (4) updates policy to conform to changes in the American Dental Association's 2014 CDT Dental Procedure Codes (this includes addition, deletion, and

renaming of codes, as appropriate); and (5) changes limitations for a number of specific procedures.

The Department made numerous changes to the final rule from the proposed rule, in response to comments, and also on the advice of the Office of the Attorney General.

Fiscal impact of rule:

The Department estimates that the General Fund impact of these changes are: $95,921 in SFY 2014 ($40,740 of which was appropriated by the Legislature in P.L. 2011 ch. 457); and $201,341 in SFY 2015 ($54,320 of which was appropriated by the Legislature in P.L. 2011, ch. 457).

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173; P&S L 2013 ch. 29; 5 MRSA §8054
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II Section 4**, Ambulatory Surgical Center Services *(New)*
Filing number:	**2014-133**
Effective date:	7/1/2014
Type of rule:	Routine technical
Emergency rule:	Yes

Principal reason or purpose for rule:
(No Fact Sheet filed)

Basis statement:
The Department is adopting this rule in order to comply with Private and Special Law 2014, Ch. 29, which became law on April 30, 2014 without the Governor's signature, and was enacted with an emergency preamble to be effective immediately. This emergency rule-making restores coverage for services provided through a section of the *MaineCare Benefits Manual*, Section 4, "Ambulatory Surgical Center Services" that was previously eliminated, in Public Law 2011, Ch. 657. This rule provides for the reimbursement of ambulatory surgical centers (ASCs) under the MaineCare program, effective July 1, 2014, under rules that are identical to the rules that were in effect on January 1, 2012. The 125th Legislature determined that the elimination of coverage for ASC resulted in access problems for MaineCare beneficiaries, and resulted in a shift of services to more expensive settings. The immediate restoration of coverage for ASC services will address access problems and reduce costs in the MaineCare program.

The Department is seeking approval of a State Plan Amendment from the Centers for Medicare and Medicaid Services.

Fiscal impact of rule:
Per the Private and Special Law, the Department estimates that there is no General Fund impact.

This rule-making will not impose any costs on municipal or county governments, or on small businesses employing fewer than twenty employees.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173; 45 CFR §§ 162.1000, 162.1002, 162.1011
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. III Section 109**, Speech and Hearing Services
Filing number:	**2014-134**
Effective date:	7/6/2014
Type of rule:	Routine technical
Emergency rule:	No

Principal reason or purpose for rule:

These rule changes implement new rates and codes for Section 109, "Speech & Hearing Services".

The Department utilizes federal Medicare rates as the basis for its rates of reimbursement for Medicaid services. In addition, pursuant to 45 C.F.R. §§ 162.1000 and 162.1002, the Department uses the Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) code sets for the coding of its Medicaid services. The code sets and Medicare rates are periodically updated by the American Medical Association CPT Editorial Panel and the federal Department of Health and Human Services, respectively. Pursuant to 45 C.F.R. §162.l001, each code set is valid within the dates specified by the organization responsible for maintaining that code set.

The codes utilized for Speech and Hearing Services were recently updated by the American Medical Association CPT Editorial Panel, in October of 2013, with a generally intended effective date of January 1, 2014. In addition, the Medicare rates for Speech and Hearing Services also changed, and the Department received notice of those rates from CMS on or about January 6, 2014.

The changes made to this rule align with current 2014 CPT codes and current Medicare rates for Speech and Hearing Services. These changes include the elimination of code 92506 with the addition of codes 92521, 92522, 92523, and 92524.

The Department is seeking approval from CMS of the proposed changes to the pertinent State Plan Amendment.

Basis statement:

This rule is being adopted, subject to approval by the Centers for Medicare and Medicaid Services, to reflect current industry standards, and to ensure compliance with federal requirements for Speech and Hearing Services, pursuant to 42 CFR §§ 440.110 and 447.201. The Department utilizes federal Medicare rates as the basis for its rates of reimbursement for Medicaid services. In addition, pursuant to 45 C.F.R. §§ 162.1000 and 162.1002, the Department uses the Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) code sets for the coding of its Medicaid services. The code sets and Medicare rates are periodically updated by the American Medical Association CPT Editorial Panel and the federal Department of Health and Human Services, respectively. Pursuant to 45 C.F.R. §162.1001, each code set is valid within the dates specified by the organization responsible for maintaining that code set.

The codes utilized for Speech and Hearing Services were recently updated by the American Medical Association CPT Editorial Panel, in October of 2013, with a generally intended effective date of January 1, 2014. In addition, the Medicare rates for Speech and Hearing Services also changed, and the Department received notice of those rates from CMS on or about January 6, 2014.

The adopted changes made to this rule align with current 2014 CPT codes and current Medicare rates for Speech and Hearing Services. These changes include the elimination of code 92506 with the addition of codes 92521, 92522, 92523, and 92524.

Fiscal impact of rule:

The Department estimates that these changes will result in a State cost of $14,766.89 for SFY 2014 and $29,631.98 for SFY 2015. The Department does not anticipate this rule-making will impose any costs on municipal or county governments, or on small businesses employing fewer than twenty employees.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	42 U.S.C. §§ 1396a(a)(43) and 1396d(r); 42 CFR §§ 440.110, 441.56
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II & III Section 35**, Hearing Aids and Services
Filing number:	**2014-149**
Effective date:	7/27/2014
Type of rule:	Routine technical
Emergency rule:	No

Principal reason or purpose for rule:

The changes to the rule add digital hearing aids as a covered service for eligible members through MaineCare, to reflect current industry standards. In addition, the changes require that providers use the State of Maine Division of Purchases' vendors that are contracted through the Hearing Aid Procurement Program as the sole suppliers of all digital hearing aids for MaineCare members under the age of 21.

Basis statement:

This rule is being adopted, subject to approval by the Centers for Medicare and Medicaid Services, to reflect current industry standards and to ensure compliance with the federal requirements for Early and Periodic Screening, Diagnostic and Treatment Services, pursuant to 42 D.S.C. §§ 1396a(a)(43) and 1396d(r), and 42 C.F.R. §441.56, which requires that digital hearing aids be covered for eligible members.

These changes reflect current industry standards and ensure compliance with the federal requirements for Early and Periodic Screening, Diagnostic and Treatment Services, pursuant to 42 D.S.C. §§ 1396a(a)(43) and 1396d(r), and 42 CFR §§ 440.110 and 441.56. This rule requires that providers use the State of Maine Division of Purchases' vendors that are contracted through the Hearing Aid Procurement Program as the sole suppliers of all digital hearing aids for MaineCare members under the age of 21. Contracted hearing aid vendors and pricing information can be found at: http://www.maine.gov/purchases/contracts/hearingaids.shtml . The Department is also adopting the following changes:

a) Adding digital hearing aid codes V5246, V5252, V5253, V5256, V5257, V5260, and V5261;
b) Allowing current dispensing fee codes V5090, V5110, V5160, V5200, V5240, and V5241 to be billed for digital hearing aids; and
c) Adding a definition for Prior Authorization.

Fiscal impact of rule:

The Department estimates that these changes will result in a cost of $7,713.71 for State Fiscal Year 2014, and $15,430.64 for State Fiscal Year 2015. This rule-making will not be adopted until State Fiscal Year 2015, but codes were allowed to be billed as of January 1, 2014 through a methodology notice. This rule-making will not impose any costs on municipal or county governments, or on small businesses employing fewer than twenty employees.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II Section 67**, Nursing Facility Services
Filing number:	**2014-155**
Effective date:	8/3/2014
Type of rule:	Routine technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule is being proposed in order to make brain injury eligibility for Section 67: Nursing Facility Services and Section 18: "Home and Community Based Services for Members with Brain Injury", consistent between policies. Individuals with Acquired Brain Injury will be eligible for Nursing Facility services if they score three or higher in two items on the Mayo-Portland Adaptability Inventory and score a 0.1 or higher on the Brain Injury Health and Safety Assessment.

This rule-making also:

a) Updates the Brain Injury definition in Section 67.01-22 to be consistent with the definition developed in Title 22 §3086
b) Adds the word "Acquired" to "Brain Injury" to be consistent with Title 22 §3086
c) Changes "Brain Injury" to "Acquired Brain Injury," and "BI" to "ABI" in the table of contents and on pages 4, 14, 32, 46, 47, 52
d) Requires, for Nursing Facilities working with individuals with brain injury, that all staff have expertise in brain injury rehabilitation as demonstrated by achieving the Certified Brain Injury Specialist (CBIS) designation from the Academy of Certified Brain Injury Specialists, or through an approved equivalent training program
e) Reorganizes Section 67.02-5
f) Corrects a numbering error in Section 67.05-13

Basis statement:

The Department recently received CMS approval for a new Home and Community Based Services waiver for individuals with brain injury, aged 18 and over. In conjunction with same, the Department is developing a new section of the *MaineCare Benefits Manual*, Section 18. The purpose of the new waiver and Section 18 is to provide more non-institutional services and options for individuals with Acquired Brain Injury. The changes to Section 67 are being adopted in order to make brain injury eligibility and the providers' requirements for Section 67, "Nursing Facility Services", consistent with the new Section 18, "Home and Community Based Services for Members with Brain Injury".

Individuals with Acquired Brain Injury will be eligible for Nursing Facility services if they score three or higher in two items on the Mayo-Portland Adaptability Inventory and score a 0.1 or higher on the Brain Injury Health and Safety Assessment. The changes also require, for Nursing Facilities receiving an enhanced rate for their work with individuals with acquired brain injury, that all direct care staff have expertise in brain injury rehabilitation as demonstrated by achieving the Certified Brain Injury Specialist (CBIS) designation from the Academy of Certified Brain Injury Specialists, or through a Department-approved equivalent training program.

This rule-making also: a) Updates the Brain Injury definition in Section 67.01-22 to be consistent with the definition developed in 22 MRS §3086 and the definition used in the new Section 18; b) Adds the word "Acquired" to "Brain Injury" in various places where the term is used, to be consistent with 22 MRS §3086; c) Changes "Brain Injury" to "Acquired Brain Injury," and "BI" to "ABI" in the table of contents and on pages 4, 14, 27, 28, 45, 46, 47, 51; d) Reorganizes Section 67.02-5; e) Corrects a numbering error in Section 67.05-13.
In response to comments, the Department has clarified that all 'direct care' staff, rather than all nursing facility staff are expected to be CBIS compliant.

Additionally, the Department is making the following technical change in the adopted rule by correcting the term "Mentally Retarded" to "Intellectually Disabled" as required by P.L. 2012, ch. 542, §B(5), removing "If CMS approves" language for changes that have been approved in sections 67.05-11(C), 67.05-12 and 67.05-14(B); and changing the formatting of the Acquired Brain Injury definition from that of the proposed to more closely match 22 MRS §3086.

Fiscal impact of rule:

In SFY 2015 this policy is expected to cost a total of $429,180.00, $164,470.36 of which will come from state funding. These funds were already allocated.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173; PL 2013 ch. 368 §SS-2
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II Section 21**, Home and Community Benefits for Adults with Intellectual Disabilities or Autistic Disorder
Filing number:	**2014-187**
Effective date:	9/1/2014
Type of rule:	Routine technical
Emergency rule:	No

Principal reason or purpose for rule:

Section 21 services are governed by a Centers for Medicare and Medicaid (CMS) Medicaid waiver. On April 18, 2014, CMS approved changes to the Section 21 waiver, effective July 1, 2014, adding new services and clarifying other services as requested by the Department. This rule change implements the approved changes.

The Department added three new services: Assistive Technology, Career Planning and Home Support-Remote Support. The Department split the existing Home Support service into four separate services: Home Support-Agency Per Diem, Home Support-Family Centered Support, Home Support-Quarter Hour, and Shared Living. Additionally, the Department split Work Support into two separate services: Work Support-Individual and Work Support-Group.

The Department added performance measures. The primary goal of performance measurement is to use data to determine the level of success a service is achieving in improving the health and wellbeing of members. Performance goals and performance measures have been established to monitor quality, inform, and guide reimbursement decisions and conditions of provider participation across MaineCare services. This focus on performance measurement is anticipated to enhance the overall quality of services provided and raise the level of public accountability for both the Department and MaineCare providers. Other changes to the rule included:

- The addition of Licensed Audiologists and Assistive Technology Professionals as qualified providers for the Communication Aids service.
- The addition of Certified Occupational Therapy Assistants (COTA) under the supervision of an Occupational Therapist Registered (OTR) as qualified providers for the Occupational Therapy (Maintenance) service.
- The addition of six (6) new definitions: Activities of Daily Living, Administrative Oversight Agency, Independent Contractor, Instrumental Activities of Daily Living, Prior Authorization and Utilization Review.
- The removal of the definition of Summary of Authorized Services.
- The addition of a reserved capacity category to meet the needs of members under 21 in out-of-state residential placements funded by MaineCare or State funds.
- The phase-out of the Home Support-Family Centered Support services.
- New procedures for filling vacancies in two-person agency-operated homes.
- A requirement for Section 21 applicants and their planning teams to estimate the annual budget for services in the course of applying for waiver services.
- A requirement that the Personal Plan for members electing the Home Support-Remote Support service incorporate a safety/risk plan.
- The addition of limits on Community Support services, Counseling services, Consultation services, and Employment Specialist Services.

- The addition of new provider qualifications for those Direct Support staff that provide Work Support-Individual services, Work Support-Group services, Employment Specialist Services and Career Planning services.

The Department made numerous changes to the final rule from the proposed rule, in response to comments, and also on the advice of the Office of the Attorney General. A list of the changes and the reasons for the changes can be found in the MAPA document, "Summary of Comments and Responses".

Other technical language changes were also adopted. The reason for the rule changes are to comply with the budget bill P.L. 2013, ch. 368 directing the Department to add Assistive Technology. The Department is complying also with a CMS directive to separate Home Support into separate services. The work support and career planning changes are to comply with LD 8, *Resolve, Directing the Department of Health and Human Services to provide coverage under the MaineCare program for Home Support Services for Adults with Intellectual Disabilities or Autistic Disorder*.

Basis statement:

(Same)

Fiscal impact of rule:

This rule-making is estimated to be cost neutral.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173; PL 2013 ch. 368 §SS-2; Resolve 2013 ch. 24
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II Section 29**, Support Services for Adults with Intellectual Disabilities or Autistic Disorder
Filing number:	**2014-188**
Effective date:	9/1/2014
Type of rule:	Routine technical
Emergency rule:	No

Principal reason or purpose for rule:

The Department is proposing many changes in this rule-making. The Department is adding four new services: Assistive Technology, Career Planning, Home Support-Quarter Hour and Home Support-Remote Support. Additionally, the Department is proposing to split Work Support into two separate services: Work Support-Individual and Work Support-Group. Additionally, the Department is proposing to add performance measures. The primary goal of performance measurement is to use data to determine the level of success a service is achieving in improving the health and wellbeing of members. Performance goals and performance measures have been established to monitor quality, inform, and guide reimbursement decisions and conditions of provider participation across MaineCare services. This focus on performance measurement is anticipated to enhance the overall quality of services provided and raise the level of public accountability for both the Department and MaineCare providers.

Other proposed changes to the rule include:

- The addition of seven (7) new definitions: Activities of Daily Living, Agency Home Support Authorized Agent, Instrumental Activities of Daily Living, Medical Add On, Prior Authorization and Utilization Review.
- Removing the definition of Summary of Authorized Services.
- A requirement for Section 29 applicants and their planning teams to estimate the annual cost of services in the course of applying for waiver services.
- A requirement that the Personal Plan for members electing the Home Support-Remote Support service incorporate a safety/risk plan.
- The addition of limits on Community Support services, Assistive Technology Services, Career Planning Services, Counseling Services, Consultation Services, Employment Specialist Services and Home Support-Remote Support Services.
- The addition of new provider qualifications for those Direct Support staff that provide Home Support Services, Work Support-Individual Services, Work Support-Group Services, Employment Specialist Services and Career Planning Services.

Other technical language changes are also being proposed. The reason for the rule changes are to comply with the budget bill P.L. 2013, ch. 368 directing the Department to add Assistive Technology. The Department is complying with Resolve, Ch. 24, *Resolve, Directing the Department of Health and Human Services to Provide Coverage under the MaineCare Program for Home Support Services for Adults with Intellectual Disabilities or Autistic Disorder*. This Resolve directs the Department to add Home Support as a covered Service to this waiver. The Department is also complying with a CMS directive to separate Home Support into separate services. The work support and career planning changes are to comply with Resolve, Ch. 24, *Resolve, Directing the Department of Health and Human Services to provide coverage under the MaineCare program for Home Support Services for Adults with Intellectual Disabilities or Autistic Disorder*.

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Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Basis statement:

Section 29 services are governed by a Centers for Medicare and Medicaid (CMS) Medicaid waiver. On April 18, 2014, CMS approved changes to the Section 29 waiver, effective July 1, 2014, adding new services and clarifying other services as requested by the Department. This rule change implements the approved changes.

The Department is allowing reimbursement for the following new services:

1. Assistive Technology services, which includes (a) Assistive Technology-Assessment; (b) Assistive Technology - Transmission (Utility Services); and (c) Assistive Technology Devices. Assistive Technology - Devices are limited to a cap of $6,000 per year, and Assistive Technology - Transmission (Utility Services) are limited to a cap of $50.00 per month.

2. Home Support services, which includes: (a) Home Support- Quarter Hour; (b) Home Support - Remote Support - Monitor Only; and (c) Home Support - Remote Support Interactive Support.

Additionally, the Department split Work Support into two separate services: Work Support-Individual and Work Support-Group.

Additionally, the Department is clarifying the reimbursement and billing for Work Support Group services, so that the exact reimbursement rate, depending on the number of members in the group, is indicated.

Finally, the Department is deleting Home Accessibility Adaptation services from the calculation for the Standard Unit Rate, since this service is paid per invoice, as indicated in Appendix 1.

The Department is adopting performance measures. The primary goal of performance measurement is to use data to determine the level of success a service is achieving in improving the health and wellbeing of members. Performance goals and performance measures have been established to monitor quality, inform, and guide reimbursement decisions and conditions of provider participation across MaineCare services. This focus on performance measurement is anticipated to enhance the overall quality of services provided and raise the level of public accountability for both the Department and MaineCare providers.

Other changes to the rule include:

- The addition of seven (7) new definitions: Activities of Daily Living, Agency Home Support, Independent Contractor, Instrumental Activities of Daily Living, Medical Add On, Prior Authorization and Utilization Review.
- Removed the definition of Summary of Authorized Services.
- A requirement for Section 29 applicants and their planning teams to estimate the annual budget of services in the course of applying for waiver services.
- A requirement that the Personal Plan for members electing the Home Support - Remote Support Service incorporate a safety/risk plan.
- The addition of limits on Community Support Services, Assistive Technology Services, Career Planning Services, Counseling Services, Consultation Services, Employment Specialist Services and Home Support-Remote Support Services.
- The addition of new provider qualifications for those Direct Support staff that provide Home Support Services, Work Support-Individual Services, Work Support Group Services, Employment Specialist Services and Career Planning Services.

Other technical language changes are made.

The reason for the rule changes are to comply with the budget bill P.L. 2013, ch. 368 directing the Department to add Assistive Technology. The Department is complying with Resolve, Ch. 24, *Resolve, Directing the Department of Health and Human Services to Provide Coverage under the MaineCare Program for Home Support Services for Adults with Intellectual Disabilities or Autistic Disorder*. This Resolve directs the Department to add Home Support as a

covered Service to this waiver. The Department is also complying with a CMS directive to separate Home Support into separate services. The Work Support and Career Planning changes are to comply with Resolve, Ch. 24, *Resolve, Directing the Department of Health and Human Services to provide coverage under the MaineCare program for Home Support Services for Adults with Intellectual Disabilities or Autistic Disorder*.

The Department made numerous changes to the final rule from the proposed rule, in response to comments, and also on the advice of the Office of the Attorney General. A list of the changes and the reasons for the changes can be found in the document, "Summary of Comments and Responses".

Fiscal impact of rule:

This rule-making is estimated to be cost neutral.

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Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173; PL 2013 ch. 594
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. III Section 67**, Principles of Reimbursement for Nursing Facilities
Filing number:	**2014-195**
Effective date:	8/15/2014
Type of rule:	Routine technical
Emergency rule:	Yes

Principal reason or purpose for rule:

On May 1, 2014, the Maine Legislature enacted emergency law, P.L. 2014, ch. 594 (*An Act to Implement the Recommendations of the Commission to Study Long-term Care Facilities*), which directed the Department of Health and Human Services ("Department") to amend its regulation for the MaineCare reimbursement of Nursing Facilities (MaineCare Benefits Manual, Chapter III, Section 67), to increase the rate of reimbursement beginning July 1, 2014.

Pursuant to emergency law, P.L. 2014, ch. 594, the Department is adopting this emergency rule without making the emergency findings otherwise required by 5 MRSA §8054, since the law allows the Department to do so if it provided a seven day notice and opportunity to comment on a draft rule. On June 16, 2014, the Department provided interested parties with a copy of the draft rule and opportunity to comment.

The Department carefully reviewed the comments received from the nursing facility providers, which delayed the adoption of this emergency rule.

This emergency rule has a retroactive application back to July 1, 2014 for the rule changes. Retroactive application for MaineCare reimbursement regulations is permitted by 22 MRSA §42(8) if the "reimbursement or other payments under the amended rule [is] equal to or greater than the reimbursement under the rules previously in effect." In order to comply with 22 MRSA §42(8), this emergency rule adds a provision, Principle 83 that provides:

> "On August 15, 2014, the Department adopted an emergency rule with a retroactive application date of July 1, 2014. For the period July 1, 2014 through August 15, 2014, the reimbursement or other payments under the August 15, 2014 emergency rule must be equal to or greater than the reimbursement under the rules previously in effect."

This emergency rule makes the following additional changes:

1. Establishes a new base year for nursing facilities which is the fiscal year of each nursing facility ending in calendar year 2011. The base year will be updated every two years.

2. For the routine care cost and for direct care cost, the peer group upper limit is increased to 110% of the median.

3. Eliminates the Administration and Management Expense ceiling, although those costs are still subject to allowability standards.

4. Establishes a payment to nursing facilities that have a high MaineCare Utilization rate (defined as greater than 70% MaineCare days of care). This payment is cost settled.

5. Changed the methodology for calculating each nursing facility's specific case mix index for the base year to the following: (1) first, the Department calculates the nursing facility's 2011 average direct care case mix adjusted rate by dividing each nursing facility's gross direct care payments received for their 2011 base year, by the 2011 base year MaineCare direct care resident days; (2) second, the Department calculates the nursing facility's 2011 case mix index by dividing the nursing facility's 2011 average direct care case mix adjusted rate as calculated in (1) by the nursing facility's 2005 base year direct care rate.

6. Eliminates the use of the 2009 CMS Nursing Home without Capital Market Basket Index for inflation adjustments, and substitutes: (a) the United States Department of Labor, Bureau of Labor Statistics, Consumer Price Index for Medical Care Services – Nursing Homes and Adult Day Care Services to adjust for inflation for the Routine Cost Component; and (b) the United States Department of Labor, Bureau of Labor Statistics, Consumer Price Index, Historical Consumer Price Index for Urban Wage Earners and Clerical Workers – Nursing Home and Adult Day service for the Direct care Component.

7. Provides that inflation adjustments will be done every year.

8. Amended the Direct Care Add-on Principle so that December 31, 2013, rather than July 1, 2008, is used for the inflation calculation, and the facility-specific average case mix index for the base year is used as the applicable case mix index for this calculation.

9. The Direct Care Hold Harmless Provision was amended so that the differential which will be applied is the difference between each nursing facility's direct care rate for the first fiscal year to which the July 1, 2014 amendments to the rule apply, and the nursing facility's direct care rate in effect on April 1, 2014.

10. The Routine Hold Harmless Provision was amended so that the differential which will be applied is the difference between each nursing facility's routine rate for the first fiscal year to which the July 1, 2014 amendments to the rule apply, and the nursing facility's routine rate in effect on April 1, 2014.

11. Changed the heading for Principle 81 from "Interim and Subsequent Rates" to "Interim, Subsequent, and Prospective Rates" because Principle 81 was amended to add a provision regarding Prospective Rates.

12. Added Principle 81.3 (Prospective Rate), which provides that the prospective rate, excluding fixed costs, will be adjusted down to 95.12% of all the calculated Direct Care cost components and all of the Routine Care cost components. The Final Prospective Rate will remain at 95.12%.

13. Added Principle 81.4 (Funding Adjustment), which provides that in the case of an individual nursing facility, whose rebased, adjusted direct and routine care rates totaled together are less than that nursing facility's April 1, 2014, direct and routine rates, totaled together, then the Department will make a Funding Adjustment, by adding the difference to the rebased routine rate.

P.L. 2014, ch. 594's requirement that the rule be amended to increase the specific resident classification group case mix weight that is attributable to a nursing home resident who is diagnosed with dementia is not directly applicable to the case mix methodology which is set forth in the rule, which is function or level-of-service based, and not based on diagnosis. The rule's case mix methodology already provides that a dementia patient whose condition worsens, and needs a higher level of care, is put in a case mix with a greater weight. The Department will continue to review this issue during the regular rulemaking which will follow this emergency rule-making.

CMS approval is needed for these changes, and the Department is seeking to amend its State Plan accordingly.

Basis statement:

(Same)

Fiscal impact of rule:

In FY 2014 this initiative will cost $25,432,166.00. This total includes $ 9,720,173.85 in state funds and $15,711,992.15 in federal funds.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173; 5 MRSA §8073; P.L. 2013 Ch. 368 §SS-2, Resolves 2013 ch. 24
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. III Section 21**, Home and Community Benefits for Adults with Intellectual Disabilities or Autistic Disorder
Filing number:	**2014-208**
Effective date:	8/29/2014
Type of rule:	Major substantive
Emergency rule:	Yes

Principal reason or purpose for rule:
(See Basis Statement)

Basis statement:

Pursuant to 5 MRSA §§ 8073 and 8054, the Department has determined that immediate adoption of this rule is necessary to avoid an immediate threat to public health, safety or general welfare. The Department's findings with regard to the existence of an emergency are as follows:

Section 21 services are governed by a Centers for Medicare and Medicaid (CMS) Medicaid waiver. On April 18, 2014, CMS approved changes to the Section 21 waiver, effective July 1, 2014, adding new services and clarifying other services as requested by the Department. In order to add these additional services to the waiver, the Department is amending Section 21, Ch. II to add the services, through routine technical rule-making. The Section 21, Chapter II rules will have an effective application date of September 1, 2014. However, Section 21, Ch. III is a major substantive rule, requiring the approval of the Legislature, which may take up to one year for that process. In order to be able to reimburse for the new services effective September 1, 2014, which is a benefit to the Section 21 beneficiaries, and in order to comply with the CMS-approved waiver, the Department needs to adopt these rules immediately.

This emergency major substantive rule makes the following changes, **and will be effective as of September 1, 2014:**

This emergency rule allows MaineCare reimbursement for the following new services: Home Support – Remote Support services which includes: (a) Home support-Remote Support – Monitor Only; and (b) Home support – Remote Support – Interactive Support.

This emergency rule allows MaineCare reimbursement for the following new services: Assistive Technology services, which includes: (a) Assistive Technology – Assessment services; (b) Assistive Technology – Transmission (Utility Services); and (c) Assistive Technology – Devices services. Adding these services complies with P.L. 2013, Ch. 368, PART SS, which authorized MaineCare "reimbursement for the use of appropriate electronic technology as a means of reducing the costs of supporting people currently being served…"

The Department is adding a new modifier ("U5") to the code for all of the Home Support – Family Centered Support – which indicates that the services are Family Centered Support services.

The Department is adding another new service: Career Planning services.

This emergency major substantive rule also separates out services, Home Support into four different services. Home Support-Agency Home Support (Per Diem), Home Support-Quarter Hour (1/4 hour), Home Support-Family Centered Support and Home Support-Shared Living.

The Department is deleting some of the language in the second paragraph of Principle 1900 (Billing Procedure), that relates to rates for Work Support Services – Group, and replacing the language with the actual rates per unit, depending on the number of members in a group.

This emergency rule also adds a service, which can be provided by a new type of provider: "Occupational Therapy (Maintenance) – which can be provided by a Certified Occupational Therapy Assistant (COTA) under the supervision of an Occupational Therapist Registered (OTR).

On March 18, 2014, the Department proposed rules for Ch. III Section 21, which it will provisionally adopt on or about August 20, 2014. The provisionally adopted rule cannot be permanently adopted until the Legislature approves it.

This emergency major substantive rule will remain in effect for up to one year or earlier if the Legislature approves the provisionally adopted major substantive rule.

Fiscal impact of rule:

This rule-making is estimated to be cost neutral.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173; 5 MRSA §8073; P.L. 2013 Ch. 368 §SS-2, Resolves 2013 ch. 24
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. III Section 29**, Allowances for Support Services for Adults with Intellectual Disabilities or Autistic Disorder
Filing number:	**2014-209**
Effective date:	8/29/2014
Type of rule:	Major substantive
Emergency rule:	Yes

Principal reason or purpose for rule:
(See Basis Statement)

Basis statement:
Pursuant to 5 MRSA §§ 8073 and 8054, the Department has determined that immediate adoption of this rule is necessary to avoid an immediate threat to public health, safety or general welfare. The Department's findings with regard to the existence of an emergency are as follows:

Section 29 services are governed by a Centers for Medicare and Medicaid (CMS) Medicaid waiver. On April 18, 2014, CMS approved changes to the Section 29 waiver, effective July 1, 2014, adding new services as requested by the Department. In order to add these additional services to the waiver, the Department is amending Section 29, Ch. II to add the services, through routine rulemaking. However, Ch. III, Section 29 is a major substantive rule, requiring the approval of the Legislature, which may take up to one year for that process. In order to be able to reimburse for the new services effective September 1, 2014, which is a benefit to the Section 29 beneficiaries, and in order to comply with the CMS-approved waiver, the Department needs to adopt these rules immediately.

This emergency major substantive rule makes the following changes which **will be effective as of September 1, 2014:**

1. Assistive Technology services, which includes (a) Assistive Technology-Assessment; (b) Assistive Technology – Transmission (Utility Services); and (c) Assistive Technology – Devices. Adding these services complies with P.L. 2013, ch. 368, PART SS, which authorized MaineCare "reimbursement for the use of appropriate electronic technology as a means of reducing the costs of supporting people currently being served [on the Section 29 waiver]." Assistive Technology – Devices are limited to a cap of $6,000 per year, and Assistive Technology – Transmission (Utility Services) are limited to a cap of $50.00 per month.
2. Home Support services, which includes: (a) Home Support – Quarter Hour; (b) Home Support – Remote Support – Monitor Only; and (c) Home Support – Remote Support – Interactive Support. Adding these services complies with Resolves 2013, Ch. 24 ("Resolve, Directing the Department of Health and Human Services to Provide Coverage under the MaineCare Program for Home Support services for Adults with Intellectual Disabilities or Autistic Disorder").

Additionally, the Department is clarifying the reimbursement and billing for Work Support – Group services so that the exact reimbursement rate, depending on the number of members in the group, is indicated.

Finally, the Department is deleting Home Accessibility Adaptation services from the calculation for the Standard Unit Rate, since this service is paid per invoice, as indicated in Appendix I.

On March 18, 2014, the Department proposed rules for Ch. III, Section 29, which it will provisionally adopt on or about September 1, 2014, pending Legislative approval.

This emergency major substantive rule will remain in effect for up to one year or earlier if the Legislature approves the provisionally adopted major substantive rule.

Fiscal impact of rule:

This rule-making is estimated to be cost neutral.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173; Private and Special Law 2013 ch. 29.
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II Section 4**, Ambulatory Surgical Center Services *(New)*
Filing number:	**2014-229**
Effective date:	8/29/2014
Type of rule:	Routine technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule is adopted in order to comply with Private and Special Law 2014 ch. 29, which became law on April 30, 2014 without the Governor's signature, and was enacted with an emergency preamble to be effective immediately. This rule-making restores coverage for services provided through a section of the *MaineCare Benefits Manual*, Section 4, "Ambulatory Surgical Center Services" that was previously eliminated, in Public Law 2011 ch. 657. This rule provides for the reimbursement of ambulatory surgical centers under the MaineCare program effective July 1, 2014, under rules that are identical to the rules that were in effect on January 1, 2012. The Legislature determined that the elimination of coverage for ASC resulted in access problems for MaineCare beneficiaries, and resulted in a shift of services to more expensive settings. The immediate restoration of coverage for ASC services will address access problems and reduce costs in the MaineCare program.

Basis statement:

This rule provides reimbursement for medically necessary services that can be performed at a freestanding facility that operates exclusively for the purpose of providing surgical services to persons not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following admission. This rule is dependent upon approval of a State Plan Amendment by the Centers for Medicare and Medicaid Services.

This rule is adopted in order to comply with Private and Special Law 2014 ch. 29, which became law on April 30, 2014 without the Governor's signature, and was enacted with an emergency preamble to be effective immediately. This rule-making restores coverage for services provided through a section of the *MaineCare Benefits Manual*, Section 4, "Ambulatory Surgical Center Services" that was previously eliminated pursuant to Public Law 2011 ch. 657. This rule will finally adopt the July 1, 2014 emergency rule that provided for the reimbursement of ambulatory surgical centers (ASCs) under the MaineCare program, under rules that are identical to the rules that were in effect on January 1, 2012. The Legislature determined that the elimination of coverage for ASC resulted in access problems for MaineCare beneficiaries, and resulted in a shift of services to more expensive settings.

Fiscal impact of rule:

The Department estimates that there is no General Fund impact.

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Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name: Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit: **10-144**
Statutory authority: 22 MRSA §§ 42, 3173; PL 2013 ch. 368 §A-33
Chapter number/title: **Ch. 101**, MaineCare Benefits Manual: **Ch. II & III Section 18**, Home and Community-Based Services for Adults with Brain Injury *(New)*
Filing number: **2014-264**
Effective date: 11/1/2014
Type of rule: Routine technical
Emergency rule: No

Principal reason or purpose for rule:
(See Basis Statement)

Basis statement:
The Department created a new section of the *MaineCare Benefits Manual* outlining the covered services, program requirements, and reimbursement rates for a home and community-based program for adults with Brain Injury (BI). This new MaineCare program, provided to eligible members through a Home and Community-Based Waiver approved by the Centers for Medicare and Medicaid Services, provides supports necessary to assist individuals with BI to live in the community rather than in institutional settings. Ch. II of Section 18 (titled "Home and Community-Based Services for Adults with Brain Injury") details the program requirements and services offered under the waiver. Those services include: Assistive Technology Devices and Services, Care Coordination Services, Career Planning, Community/Work Reintegration, Employment Specialist Services, Home Support, Non-Medical Transportation Services, Self-Care/Home Management Reintegration, Work Ordered Day Club House and Work Support Services-Individual. Ch. III of Section 18 (titled "Allowances for Home and Community-Based Services for Adults with Brain Injury") establishes billing procedure codes (based on HIPAA compliant CPT coding) and reimbursement rates for the waiver services.

Fiscal impact of rule:
The Department anticipates that this rule will cost approximately $6,690,000.00 in SFY 14.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173; PL 2013 ch. 594
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. III Section 67**, Principles of Reimbursement for Nursing Facilities
Filing number:	**2014-266**
Effective date:	11/13/2014
Type of rule:	Routine technical
Emergency rule:	No

Principal reason or purpose for rule:
(See Basis Statement)

Basis statement:
On August 15, 2014, the Department adopted an emergency rule, which increased MaineCare nursing facility reimbursement, as required by P.L. 2013, ch. 594 ("An Act to Implement the Recommendations of the Commission to Study Long-term Care Facilities"). The August 15, 2014 emergency rule had a retroactive application date of July 1, 2014 for the changes.

This rule seeks to make permanent those changes to nursing facility reimbursement made in the August 15, 2014 emergency rule. The August 15, 2014 emergency rule had an effective application date for the rule changes of July 1, 2014. This rule also uses the same effective application date for the changes of July 1, 2014.

This rule adopts the following changes:

1. Establishes a new base year for nursing facilities which is the fiscal year of each nursing facility ending in calendar year 2011. The base year will be updated every two years.
2. For the routine care cost and for the direct care cost, the peer group upper limit was increased to 110% of the median.
3. Eliminates the Administration and Management Expense ceiling, although those costs are still subject to allowability standards.
4. Establishes a payment to nursing facilities that have a high MaineCare Utilization rate (defined as greater than 70% MaineCare days of care). This payment is cost settled.
5. Changes the methodology for calculating each nursing facility's specific case mix index for the base year to the following: (1) the Department calculates the nursing facility's 2011 average direct care case mix adjusted rate by dividing each nursing facility's gross direct care payments received for their 2011 base year by the 2011 base year MaineCare direct care resident days; (2) the Department calculates the nursing facility's 2011 case mix index by dividing the nursing facility's 2011 average direct care case mix adjusted rate as calculated in (1) by the nursing facility's 2005 base year direct care rate.
6. Eliminates the 2009 CMS Nursing Home without Capital Market Basket Index for inflation adjustments, and substitutes : (1) the United States Department of Labor, Bureau of Labor Statistics, Consumer Price Index for Medical Care Services – Nursing Homes and Adult Day Care Services to adjust for inflation for the Routine Cost Component; and (2) the United States Department of Labor, Bureau of Labor Statistics, Consumer Price Index, Historical Consumer Price Index for Urban Wage Earners and Clerical Workers – Nursing Home and Adult Day service for the Direct care Component.
7. Adds a provision that the inflation adjustments will be done every year.

8. Amends the Direct Care Add-on Principle so that December 31, 2013, rather than July 1, 2008, is used for the inflation calculation, and the facility-specific average case mix index for the base year is used as the applicable case mix index for this calculation.

9. Amends the Direct Care Hold Harmless Provision so that the differential which will be applied is the difference between each nursing facility's direct care rate for the first fiscal year to which the July 1, 2014 amendments to the rule apply, and the nursing facility's direct care rate in effect on April 1, 2014.

10. Amends the Routine Hold Harmless Provision so that the differential which will be applied is the difference between each nursing facility's routine rate for the first fiscal year to which the July 1, 2014, amendments to the rule apply, and the nursing facility's routine rate in effect on April 1, 2014.

11. Changes the heading for Principle 81 from "Interim and Subsequent Rates" to "Interim, Subsequent, and Prospective Rates" because Principle 81 was amended to add a provision defining Prospective Rate.

12. Adds Principle 81.3 (Prospective Rate), which provides that the prospective rate, excluding fixed costs, will be calculated to be 95.12% of all the calculated Direct Care cost components and all of the Routine Care cost components. Principle 82, the Final Prospective Rate, is also defined as being no more than 95.12%.

13. Adds Principle 81.4 (Funding Adjustment), which provides that in the case of an individual nursing facility, whose rebased, adjusted direct and routine care rates totaled together are less than that nursing facility's April 1, 2014, direct and routine rates, totaled together, then the Department will make a Funding Adjustment, by adding the difference to the rebased routine rate. This language has been changed between the adoption of the emergency rule and this rule in order to clarify the process used to set the rate by breaking down the steps used to calculate the rate and setting when the Funding Adjustment will be used.

14. Added Principle 83 (August 15, 2014 Emergency Rule), to provide that for the retroactive application period of July 1, 2014, through August 15, 2015, the reimbursement to nursing facilities must be equal to or greater than the reimbursement that they had received under the rules previously in effect.

P.L. 2013, ch. 594's requirement that the rule be amended to increase the specific resident classification group case mix weight that is attributable to a nursing home resident who is diagnosed with dementia is not directly applicable to the case mix methodology which is set forth in the rule, which is function or level-of-service based, and not based on diagnosis. The rule's case mix methodology already provides that a dementia patient whose condition worsens, and needs a higher level of care, is put in a case mix with a greater weight. The Department carefully reviewed this issue but made no changes for this rulemaking.

Between the proposal and adoption, the following changes were made in response to comments:

1. The sentence, "This occupancy adjustment does not apply to High MaineCare Utilization or the Nursing Facility Health Care Provider Tax." was added to Principle 44.10, Occupancy Adjustment.

2. A second paragraph was added to Principle 44.13, High MaineCare Utilization, to explain how the payment will be audited.

3. The Department added the phrases, "as described in Principle 41" and "base year," to Principle 80.3.3(1), Source of Base Year Cost Data, as suggested by the commenter.

4. The phrase, "unless the facility qualifies for High MaineCare Utilization," was added to the end of Principles 80.3.5, Direct Care Cost Settlement, and 80.5.7, Routine Cost Settlement, as suggested by the commenter.

5. The Department added the tool used to inflate rates, the Consumer Price Index, to Principle 91.1, and specified section (4) within Principle 80.3.3 as the location in which the tool is mentioned.

CMS approval is needed for these changes. Accordingly, the Department has submitted a State Plan Amendment.

Fiscal impact of rule:

In FY 2014 this initiative will cost $25,432,166.00. This total includes $9,720,173.85 in state funds and $15,711,992.15 in federal funds.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 1901 *et seq.*, 3173
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II & III Section 30**, Family Planning Agency Services
Filing number:	**2014-268**
Effective date:	11/18/2014
Type of rule:	Routine technical
Emergency rule:	No

Principal reason or purpose for rule:
(See Basis Statement)

Basis statement:
This rule-making is being adopted in order to conform with industry billing standards and covered services. The Department is required to utilize certain applicable medical data code sets, pursuant to 45 C.F.R. §§ 162.1000 and 162.1002. Each code set is valid within the dates specified by the organization responsible for maintaining that code set pursuant to 45 C.F.R. §162.1011.

The updates include the addition of the code for the administration of medroxyprogesterone acetate (DepoProvera), and the addition of codes for the following new Family Planning Agency Services in Ch. III:

1) Removal of an IUD
2) Administration of the HPV vaccine
3) Insertion of the IUD Skyla®

Finally, these changes remove language referring to retroactive code dates from 2010. The revisions to Ch. II include a reference to a rate setting website in Ch. III and the addition of language stating that Family Planning Agencies will be reimbursed at the same fee-for-service rate as other providers, when applicable.

Between proposal and adoption the code 11981, "Insertion, non-biodegradable drug delivery implant" was added to the Ch. III Section 30, and the codes 11975 and 11977 were removed in order to comply with federal coding standards. A note was also added to the beginning of Ch. III Section 30, to indicate that the code 11981 is dependent on CMS approval.

Fiscal impact of rule:
These changes are not expected to create a measurable fiscal impact.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173; 42 U.S.C. §1396b; 42 CFR §§ 495.300 - 370
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. I Section 2**, State Medicaid Health Information Technology (HIT) Program
Filing number:	**2014-269**
Effective date:	11/23/2014
Type of rule:	Routine technical
Emergency rule:	No

Principal reason or purpose for rule:

The changes promote the protection of Protected Health Information (PHI) by implementing federal Meaningful Use and audit requirements for the State HIT Electronic Health Record (ERR) Incentive Payment Program.

Basis statement:

The adoption of this rule brings Maine into compliance with federal law (42 USC §1396(b); 42 C.F.R. §§ 495.300-370). The rule regulates the State's Health Information Technology (HIT) Electronic Health Record (EHR) Incentive Payment Program. The changes to the rule include clarifications about which entities are deemed as having a "fully implemented" EHR as well as clarifications regarding the Department's role in conducting pre-payment reviews and post-payment audits. The Department, or its agent, conducts pre-payment reviews on all participants and may conduct post-payment audits of hospitals that participate exclusively in the Medicaid incentive payment program. These activities are ongoing, and the rule is being amended to reflect these practices. Finally, a number of technical formatting edits have been made.

The Department contracts out HIT audit requirements to a third party for a total of $234,125.00 annually. The State's share of this cost is $23,413.00, with the remainder (90%) covered by federal funds.

Fiscal impact of rule:

The Department expects that this rule-making will have no fiscal impact.

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Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173; Resolve 2011 ch. 71
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II & III Section 19**, Home and Community Benefits for the Elderly and for Adults with Disabilities
Filing number:	**2014-286**
Effective date:	12/15/2014
Type of rule:	Routine technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule was proposed in order to comply with Resolve 2011, ch 71.This rule blends services from Section 19 and Section 22, "Home and Community Benefits for the Physically Disabled", and is being proposed simultaneously with the repeal of Section 22.These changes are subject to CMS approval, and a waiver amendment was submitted March 14, 2014.

Basis statement:

The Department has determined that the adoption of this rule is necessary to implement provisions in Resolve 2011, ch. 71 over which the Department has subject matter jurisdiction. As mandated by the Legislature, in Resolve 2011, ch. 71, the Department is consolidating two existing waivers for adult and elderly community-based services, Sections 19 and 22 in the *MaineCare Benefits Manual*. These changes are subject to CMS approval, and a waiver amendment was submitted March 14, 2014.

The changes adopted in this rule will maintain or increase the level of services available to members, specifically:

- The Department is removing Homemaker Services as a stand-alone service; members will receive instrumental activities of daily living as part of Personal Care or Attendant Services instead.
- Assistive Technology, Assistive Technology-Remote Monitoring and Assistive Technology-Transmission are being added as new services and are included under the program cap.
- The Department is making changes to the terminology, definitions and requirements for "Self-Direction" and "Family Provider Services Option" (FPSO). These terms are eliminated and replaced with the term "Participant Directed Option."
- The term "Supports Brokerage" has been removed and the term "Care Coordination" will be used exclusively.
- The requirement for individual managing services under the FPSO to register as an agency with the Division of Licensing and Regulatory Services has been eliminated, and the requirements for a Representative under this service delivery option have changed.
- The term "Attendant" is added to define the worker providing services for members using the Participant Directed Option and qualifications have been clarified for Attendants.
- The Department modified eligibility and termination reasons that relate solely to the Participant Directed Option.
- Qualifications for Skills Training have been added.
- Provider requirements for out-of-state services have been clarified.
- The Department clarified the number of hours weekly an individual worker may provide to an individual member or household.
- The Department standardized requirements regarding face-to-face visits from the Service Coordination Agency.
- The Department clarified qualifications for Care Coordination staff.
- The Department changed certain definitions.

- The Department clarified the components of the Attendant rate and Financial Management Service.
- The Department clarified the responsibilities of the Financial Management Service regarding background checks and Office of Inspector General checks.
- The Department allowed certain individuals who meet specific eligibility to exceed a monthly cap by a certain percentage.
- The Department increased the limit for Care Coordination to 24 hours annually.
- The Department clarified the dollar month cap allowable per member per month under this waiver.
- The Department modified the licensed settings which qualify for reimbursement for respite services.

The Department changed rates to be consistent between the former Section 19 and Section 22 programs in Ch. III.

Additional Changes Adopted after the Proposed Rule

Global changes

All defined terms have been changed to uppercase throughout the policy section.

Various minor typographical and grammatical errors were corrected throughout the policy section.

The majority of terms changed to Care Plan and Plan of Care have been made consistent and changed to Plan of Care.

The term Direct Care Provider has been clarified and made consistent throughout the policy section.

Specific sections

19.01-4. The reference to the licensing regulations for Adult Family Care Homes has been corrected.

19.01-5. The word "prior" was inserted before the term "authorized" for clarity and consistency throughout this section.

19.01-16. The definition of Choice Letter was changed to clarify that the Choice Letter must be signed by the member or a legal agent of that member.

19.01-19. The definition of Direct Care provider was clarified to state that it is a MaineCare provider that directly provides Adult Day, Personal Care, Home Health or In-home Respite services under Section 19.

19.01-26. The definition of IADL was clarified to state that assistance with laundry may be provided "within the residence or at an outside laundry facility."

19.01-31. The term "person" was changed to the term "individual."

19.03-1(B). Language was clarified to be specific about what services may not be declined by a member and still maintain eligibility for the Section 19 program.

19.03-1(P). This section was added to respond to a comment and clarify the timeframe for compliance.

19.03-2(e). Language was added in response to a comment to provide clarity and consistency within the meaning of the rule, to indicate that it is grounds for terminating the Participant Directed option if at any time a member is without an Attendant for sixty days, either upon initial hire or at any point during the program, unless services are under suspension.

19.03-3. Language has been clarified to reflect that the service that may be provided by the SCA is Care Coordination services.

19.03-4. Language was added in response to a comment to provide clarity and consistency within the meaning of the rule.

19.04-2. Language has been added to clarify that services must be medically necessary.

19.04-3(f). Language was added in response to a comment to add significant risk of wandering to be considered in evaluating the need for assistive technology. Language was also added stating that the back-up planning needed to be completed prior to a referral for this service to the WSP.

19.04-5(A)(1). Language was added in response to a comment to provide clarity and consistency within the meaning of the rule.

19.04-5(A)(14.) In response to comments, deleted the words "health status or change in service need" and replaced them with the term "Significant Service Change," which is already a defined term and provides the basis for an unscheduled reassessment.

19.04-5(A)(16). Language was clarified to be more specific about the authorization process from MeCare to the State's claims system, MIHMS

19.04-6(E). Language was added to ensure that environmental modifications are not duplicative of other services.

19.04-8. The words "home health" have been added before the word "provider" to clarify the specific provider being referenced in this sentence.

19.04-8(G). The term "social worker plan of treatment" was changed to "medical treatment plan" to provide clarity and consistency within the meaning of the rule.

19.04-12. The word "Medical" was removed in reference to transportation in order to accurately reference the title of Section 113 of the MBM.

19.05(H). Language was added to Non-Covered Services to reflect that food may be covered as part of Adult Day Services as allowed in Section 19.04.

19 .05(L). Language was added to allow for a transition time until 1/1/2015 for the requirement that an individual worker may not work for more than 40 hours per week for an individual member or household.

19.06(C). Limits on FMS were pulled into a separate section and clarifies that these costs are not part of the monthly program cap calculation.

19.06(I). In response to a comment, the weekly cap on personal care services was changed from 86 hours weekly to 86.25 to match the current cap on this service under Section 22.

Section 19.07(A)(I). Language added clarifying role of the ASA in providing choice of SCA to the members.

Section 19.07(C) Language was added to clarify the SCA submits service authorizations through MeCare to the Department's MaineCare claims system.

19.08(B)(4)(a)(ii)(cc). Language was changed to provide clarity around terminology regarding the CNA Registry. The word "lapsed" was deleted and replaced with "has become inactive" to refer to an individual's status on the registry.

19.08(B)(5). Language was added in response to a comment to provide clarity and consistency within the meaning of the rule.

19.08(B)(7). Language was added to allow for a transition time until 1/1/2015 for the requirement that Representatives under the Consumer Directed option visit the member at least monthly and contact the member at least weekly.

Section 19.08-5(C). Language was clarified to reflect that home health agencies are responsible for maintaining a nursing plan of care signed by a physician.

19.08-6. Language was deleted regarding member appeals to remove language duplicative of Section 1.22 of the *MaineCare Benefits Manual*.

Fiscal impact of rule:

This rule-making is expected to be cost neutral.

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Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II & III Section 22** *(Repeal)*, Home and Community Benefits for the Physically Disabled
Filing number:	**2014-290**
Effective date:	12/27/2014
Type of rule:	Routine technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule is being repealed and incorporated into Section 19, "Home and Community Based Benefits for the Elderly and for Adults with Disabilities". This rule is complies with Resolve 2011, ch. 71.This rule blends services from Section 19, "Home and Community Benefits for the Elderly and for Adults with Disabilities" and Section 22, "Home and Community Benefits for the Physically Disabled". These changes are subject to CMS approval, a waiver amendment was submitted March 14, 2014.

Basis statement:

The Department has determined that the repeal of this rule is necessary to implement provisions in Resolve 2011, ch. 71 over which the Department has subject matter jurisdiction. As mandated by the Legislature, in Resolve 2011, ch. 71, the Department is consolidating two existing waivers for adult and elderly community-based services, Sections 19 and 22 in the *MaineCare Benefits Manual*. These changes are subject to CMS approval.

This rule-making will not impose any costs on municipal or county governments, or on small businesses employing fewer than twenty employees.

Fiscal impact of rule:

This rule-making is estimated to be cost neutral.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42(8), 3173
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II Section 14**, Advanced Practice Registered Nursing Services
Filing number:	**2014-294**
Effective date:	12/28/2014
Type of rule:	Routine technical
Emergency rule:	No

Principal reason or purpose for rule:

The purpose of this rule-making is to clarify the amount of reimbursement for Advanced Practice Registered Nurses (APRNs). The policy currently states that MaineCare will reimburse APRNs providing psychological or psychiatric services at 60% of the amount reimbursed for physicians' services, leaving the policy inconsistent with both practice and Maine's State Plan. The rule seeks to change that rate to the amount reimbursed for physicians' services as set forth in Section 90, “Physician Services”. The rule change is being made retroactive to January 1, 2013. This rule-making also makes technical changes.

In addition, if the Centers for Medicare and Medicaid Services (CMS) approves, the rule proposes to reimburse Certified Registered Nurse Anesthetists (CRNAs) at 75% of the amounts of reimbursement for services as set forth in Section 90. This is the reimbursement rate that MaineCare has been paying CRNAs.

The Department shall submit proposed State Plan changes to CMS to reflect these clarifications.

Basis statement:

The Department has determined that the adoption of this rule is necessary to implement policy changes that reflect current practice. Rates were established at a level that ensures member access to services. Rates paid to Certified Registered Nurse Anesthetists providing anesthesiology services were established at a reduced rate to reflect the required supervision of a physician.

Fiscal impact of rule:

This rule is not expected to have any fiscal impact; the services are already being reimbursed at the rate reflected in this rule change as mandated in Maine's State Plan.

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Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173; PL 2013 ch. 444
Chapter number/title:	**Ch. 101**, MaineCare Benefits Manual: **Ch. II Section 103**, Rural Health Clinic Services
Filing number:	**2014-295**
Effective date:	12/28/2014
Type of rule:	Routine technical
Emergency rule:	No

Principal reason or purpose for rule:

The proposed rule proposes the following changes:

1. Per Public Law 2014, ch. 444 ("An Act to Reduce Tobacco-Related Illness and Lower Health Care Costs in MaineCare"), effective 8/1/14, eliminates the three times per year limit on tobacco counseling and specifies that Smoking cessation counseling is exempt from any copayment requirement.

This change is being made effective August 1, 2014, which will be a retroactive application date (since this rule will not be adopted until Fall 2014). The Department is authorized to adopt rules with retroactive application, pursuant to 22 MRSA §42(8), when necessary to conform to the State plan and to maximize federal Medicaid funding, and where there is no adverse financial impact on any MaineCare provider or Member. Here, because there is a positive impact on MaineCare providers and Members, since the Department is eliminating limits and copayments for tobacco counseling.

2. The Department deleted language that identified a specific ICD-9 diagnosis code (ICD-9 diagnosis code of 305.1 [tobacco use disorder]), and in its place is proposing more general language referencing "a nicotine or tobacco dependence code from the applicable version of the ICD Manual required by CMS." Federal law, 45 CFR Sec 162.1000, requires covered entities such as the Maine Office of MaineCare Services, to utilize the Medical data code sets (including ICD Manuals) as specified in the federal regulation that are valid at the time the health care is provided. As of the date this rule became effective, CMS, and the Office of MaineCare Services, utilized the *International Classification of Diseases*, 9th Edition, "Clinical Modification", (ICD-9-CM), and Volume 3 Procedures (including The Official ICD-9-CM Guidelines for Coding and Reporting). CMS has notified states that it intends to switch to the ICD-10 Manual at some time in the future.

Basis statement:

The Department has determined that the adoption of this rule is necessary to implement provisions in Public Law 2014, ch. 444 (*An Act to Reduce Tobacco-Related Illness and Lower Health Care Costs in MaineCare*) over which the Department has subject matter jurisdiction.

This change is made effective August 1, 2014, a retroactive application date. The Department is authorized to adopt rules with retroactive application, pursuant to 22 MRSA 42(8), when necessary to conform to the State Plan and to maximize federal Medicaid funding, and where there is no adverse financial impact on any MaineCare provider or member. Here, there is a positive impact on MaineCare providers and members, since the Department is eliminating limits and copayments for tobacco cessation counseling.

Please note that, pursuant to P.L. 2014 Ch. 444 and section 2502 of the *Affordable Care Act*, smoking cessation products are unrestricted covered services for eligible members, effective as of August 1, 2014. Tobacco cessation products are "Covered Drugs," reimbursable pursuant to Ch. II Section 80.05 of the *MaineCare Benefits Manual*. As Covered Drugs, tobacco cessation products are included on the Department's Preferred Drug List (PDL), as set forth in Ch. II Section 80.07-5, which PDL may be accessed via the Department's website.

There are no co pays or other limits on tobacco cessation products, and MaineCare members are not required to participate in tobacco cessation counseling in order to receive tobacco cessation products.

The Department deleted language that identified a specific ICD-9 diagnosis code (ICD-9 diagnosis code of 305.1 [tobacco use disorder]), and in its place is more general language referencing "a nicotine or tobacco dependence code from the applicable version of the ICD Manual required by CMS." Federal law, 45 CFR Sec 162.1000, requires covered entities such as the Office of MaineCare Services, to utilize the Medical data code sets (including ICD Manuals) as specified in the federal regulation that are valid at the time the health care is provided. As of the date this rule became effective, CMS, and the Office of MaineCare Services, utilized the *International Classification of Diseases*, 9th Edition, "Clinical Modification", (ICD-9-CM), and Volume 3 Procedures (including the Official ICD-9-CM Guidelines for Coding and Reporting). CMS has notified states that it intends to switch to the ICD-10 Manual at some time in the future.

This rule-making will not impose any costs on municipal or county governments, or on small businesses employing fewer than twenty employees.

Fiscal impact of rule:

The Department estimates that there is no General Fund impact.

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Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office of MaineCare Services - Division of Policy**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173, 3174-RR
Chapter number/title:	**Ch. 104**, Maine State Services Manual: **Section 6**, Independent Practice Dental Hygienist Services
Filing number:	**2014-129**
Effective date:	7/1/2014
Type of rule:	Routine technical
Emergency rule:	No

Principal reason or purpose for rule:

§3174-RR requires that by October 1, 2012, the department shall provide for the reimbursement under the MaineCare program of IPDHs practicing as authorized under Title 32 MRS §1094-I for the following procedures:

A. Prophylaxis performed on a person who is 21 years of age or younger;
B. Topical application of fluoride performed on a person who is 21 years of age or younger;
C. Provision of oral hygiene instructions;
D. The application of sealants;
E. Temporary fillings; and,
F. X-rays.

22 MRS §3174-RR also specifies that reimbursement must be provided to IPDHs directly or to a federally qualified health center pursuant to 22 MRS §3174-V when an IPDH is employed as a provider at the center, and that the department shall adopt rules to implement this section.

This rule serves to implement state-only reimbursement of IPDHs as set forth above pending approval by the Centers for Medicare and Medicaid Services of a State Plan Amendment (SPA) to add IPDHs as a MaineCare provider under Maine's State Plan. These rules will expire upon the effective date of that SPA and shall be superseded at that time by the IPDH subsection of Ch. 101, *MaineCare Benefits Manual* (MBM), Ch. II & III Section 25, "Dental Services", and by the addition of IPDHs to MBM Ch. II Section 31, "Federally Qualified Health Center Services".

Basis statement:

This rule implements a state-only funded program to provide reimbursement for Independent Practice Dental Hygienists (IPDHs) services and to Federally Qualified Health Centers (FQHCs) employing IPDHs for certain services, provided to MaineCare Members during the period October 1, 2012 through September 30, 2013.

The Department establishes this program only for this retroactive time period for the following reason: in 2012 the Maine Legislature enacted a law [P.L. 2011, ch. 457, as codified in 22 MRSA §3174-RR] requiring the Department, by October 1, 2012, to reimburse IPDHs and FQHCs employing IPDHs under the MaineCare program for certain services provided to eligible MaineCare Members. The Department was required to get approval from the Centers for Medicare and Medicaid (CMS) for this new type of MaineCare provider. As of the effective date of this rule, (July 1, 2014), the Department had not yet gotten CMS approval, and the earliest effective date of CMS approval would be October 1, 2013. Accordingly, the purpose of this rule is to comply with Legislative intent, and allow IPDHs and FQHCs who employed IPDHs to be reimbursed for services they provided to eligible

MaineCare members for the period of time October 1, 2012 through September 30, 2013, through this state-only funded program.

This state-only funded service reimburses IPDHs and FQHCs who employed IPDHs providing such services, during the period October 1, 2012 through September 30, 2013, for the following services provided to individuals who were eligible MaineCare members at the time of service: prophylaxis performed on a person who was 21 years of age or younger; topical application of fluoride performed on a person who was 21 years of age or younger; provision of oral hygiene instructions; the application of sealants; temporary fillings; and processing and exposing radiographs (X-rays).

To be reimbursed, IPDHs and FQHCs must be enrolled as MaineCare providers on the date they submit claims. Additionally, FQHC's must have been enrolled as MaineCare providers on the date of the service. If the FQHC had been reimbursed by MaineCare for an ambulatory clinic visit for the MaineCare Member, on the same date as the IPDH service, the FQHC is ineligible for IPDH reimbursement under this rule.

Providers must submit claims on or before December 31, 2014, in order to be reimbursed.

The Department made numerous changes to the final rule from the proposed rule, in response to comments, and also on the advice of the Office of the Attorney General.

Fiscal impact of rule:

The Department estimates that the General Fund impact of these changes are: $147,890 in SFY 2013 ($54,320 of which was appropriated by the Legislature in P.L. 2011 ch. 457) and $90,517 in SFY 2014 ($13,580 of which was appropriated by the Legislature in P.L. 2011, ch. 457).

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Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Division of Licensing and Regulatory Services**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS ch. 1684; 22 MRS §42; 22-A MRS §205
Chapter number/title:	**Ch. 114**, Rules Governing the Reporting of Sentinel Events
Filing number:	**2014-267**
Effective date:	1/1/2015
Type of rule:	Routine technical
Emergency rule:	No

Principal reason or purpose for rule:
(See Basis Statement)

Basis statement:
The purpose for amending this rule is to remove from Section 1 duplicate sentinel events that are also listed in the appendix of the rules: "Appendix A: NQF 2011 List of Serious Reportable Evens". (National Quality Forum (NQF), Serious Reportable Events in Healthcare 2011, Washington, DC: NQF, 2011.)

A number of definitions that were closely aligned with National Quality Forum (NQF) definitions have been standardized for consistency. Other changes delete the definitions of "hyperbilirubinemia" and "hypoglycemia"; add definitions of "injury" and "patient"; and move "incorporation by reference" from Section 1 to Section 8.9 of the rules. Section 3.3.2.2 adds "at a healthcare facility" and deletes "in an emergency department, ambulatory surgical facility, or end-stage renal disease facility".

Some language that was formerly in the definition section has been moved to Section 3.3.3 and 3.3.4 regarding when a facility is required to report a sexual assault or a serious event to the sentinel events team. Section 4.1 adds that the primary emphasis is to ensure effective corrective action. Section 8 adds failure to comply with the rules may result in an enforcement action. As necessary, the rules are renumbered and statutory citations added.

The changes will provide greater regulatory clarity by removing redundancy.

Fiscal impact of rule:
This rule is not expected to fiscally impact or create new recording burdens for healthcare facilities. This rule is not expected to yield new costs for municipal or county governments.

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Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, Maine Center for Disease Control and Prevention, Division of Environmental Health, **Healthy Home & Lead Poisoning Prevention Program**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §1322-F
Chapter number/title:	**Ch. 293**, Maine Lead Poisoning Prevention Fee Rules
Filing number:	**2014-005**
Effective date:	1/15/2014
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

The rule change is intended to make the Rules consistent with the 2007 updates to Section 4 of 22 MRS §1322-F, which change the contingent repeal from a specific date to a time when the Commissioner of the Department certifies that a period of 24 months has elapsed since the Department identified a child with an elevated blood lead level.

Basis statement:

The adoption of this Rule implements a change that makes it consistent with Maine's *Lead Poisoning Control Act*. In 2007, the *Lead Poisoning Control Act* (22 MRS §1322-F) was changed: instead of providing an end date of July 2011for the assessment of lead poisoning prevention fees, the statute was amended to indicate an end date of 24 months from the date when there is no identified child with an elevated blood lead level. Presently, there are still a number of elevated lead poisoning cases among children in the state of Maine.

This Rule determines which manufacturers or wholesalers of paint are responsible for the fees imposed for paint sold in Maine. Within the Rule, a method is established for calculating the number of gallons sold, and subsequently, the amount of corresponding payment required.

Because the statute was changed in 2007, this rule change is not expected to cause any point of public controversy. No member of the public attended the public hearing on September 6, 2013, and no public comment was submitted. This rule will not yield new administrative burdens or compliance-related costs on municipal or county governments. The fees only apply to manufacturers and wholesalers of paint sold in Maine. There is an exception for this fee, if the amount sold is fewer than 1,800 gallons. (See 10-144 CMR 293, Sections 1(H) and 2(D)).

Fiscal impact of rule:

There are no expected fiscal impacts of this rule on municipalities. There will be no additional fiscal impacts on the regulated community. These changes only clarify statutory requirements already in place.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3104 and 5 MRSA §8054
Chapter number/title:	**Ch. 301**, Food Supplement Program, **Rule #185E**: Full Standard Utility Allowance Based on the Receipt of Energy Assistance
Filing number:	**2014-210**
Effective date:	8/29/2014
Type of rule:	Routine Technical
Emergency rule:	Yes

Principal reason or purpose for rule:

The Supplemental Nutrition Assistance Program (SNAP) was recently reauthorized as part of *The Agricultural Act* (the Act) *of 2014* (P.L.113-79) enacted on February 7, 2014. The law contains various provisions that affect Food Supplement eligibility, benefits, and program administration.

Basis statement:

The Supplemental Nutrition Assistance Program (SNAP) was recently reauthorized as part of *The Agricultural Act* (the Act) *of 2014* (P.L.113-79) enacted on February 7, 2014. The law contains various provisions that affect Food Supplement eligibility, benefits, and program administration.

The federal provision requires that households receive a payment greater than $20 annually in Low Income Heating Assistance Program (LIHEAP) benefits or in other similar energy assistance benefits in the current month or in the immediately preceding 12 months in order to automatically qualify for the Full Standard Utility Allowance (FSUA) based on receipt of LIHEAP.

The United States Department of Agriculture (USDA), Food and Nutrition Services (FNS) set an effective date of March 5, 2014, for implementation of the reduced allotments. States will be held harmless for 120 days from March 10, 2014, for quality control variances.

The final approved values were not provided in a timeframe that would allow the department to comply with the regular rulemaking process. Failure to adopt the new standard utility allowances based on the receipt of energy assistance will result in overpayments. An emergency rule change is necessary to preclude federal penalties or loss of federal funds and thereby avoid threats to the public health, safety and general welfare.

Fiscal impact of rule:

There will be General Fund savings of approximately $84,460 for state-funded benefits during the period of September 2014 through June 2015.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(1), 3104; 7 CFR 273.7
Chapter number/title:	**Ch. 301**, Food Supplement Program, **Rule #187A**: General Program Requirements / Nonfinancial Eligibility Factors
Filing number:	**2014-230**
Effective date:	10/1/2014
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

Federal SNAP regulations have been in place since 1996 that limit ABAWDs to 3 months of SNAP benefits in a 36-month period if they do not meet work requirements. Although most states have waived this requirement in recent years due to high unemployment rates, many states are now enforcing work requirements as unemployment rates decrease nationwide. Maine unemployment rates have decreased to 5.5% (seasonally adjusted, April, 2014), no longer requiring an exemption for ABAWDs. Maine will enforce work requirements for SNAP ABAWDs statewide, which is currently about 12,000 SNAP recipients.

Basis statement:

The Department is adopting changes that, as of October 1, 2014, will require Maine Supplemental Nutrition Assistance Program (SNAP) recipients who are able bodied adults between the ages of 18-49 without dependents (ABA WDs) to meet the work requirements of the federal SNAP program. This change will not impact SNAP recipients not meeting the age requirements, or those who are temporarily or permanently disabled, have dependent children in the household, are caring for an incapacitated adult, are currently receiving substance abuse treatment, are in school at least half-time, or are pregnant. ABA WDs will be limited to 3 months of benefits in a fixed 36-month period (beginning October 1, 2014) if they do not meet work requirements of 20 hours a week, participating in employment and training services or other approved work activities.

Federal SNAP regulations have been in place since 1996 that limit ABA WDs to 3 months of SNAP benefits in a 36-month period if they do not meet work requirements. Because unemployment rates have decreased and since many jobs listed at the Maine CareerCenters go unfilled, there is no longer need for a waiver from this work requirement. There are currently over 7,000 jobs posted on the Maine Job Bank. Over 20,000 jobs have been created since 2010 and the unemployment rate is down to 5.5% from 6.7% a year ago. Maine has the lowest unemployment rate now than at any point since the recession in 2008. The Department believes the economy in Maine has recovered sufficiently, as evidenced by the decrease in the unemployment rate, to require these food stamp recipients, who are working-age and able-bodied, to do some amount of work to continue receiving this benefit.

Maine will enforce work requirements for SNAP ABA WDs statewide as of October 1, 2014, which will impact approximately 12,000 SNAP recipients. The Department expects that the fiscal impact to municipalities will be minimal, because most of the ABA WDs impacted by these rule changes should be able to find jobs that improve their financial stability.

Fiscal impact of rule:

There will be no fiscal impact.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3104
Chapter number/title:	**Ch. 301**, Food Supplement Program, **Rule #185A**: Full Standard Utility Allowance Based on the Receipt of Energy Assistance, Annual SUA, COLA and Resources
Filing number:	**2014-273**
Effective date:	12/1/2014
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

The Supplemental Nutrition Assistance Program (SNAP) was recently reauthorized as part of *The Agricultural Act (the Act) of 2014* (P.L. 113-79) enacted on February 7, 2014. The law contains various provisions that affect Food Supplement eligibility, benefits, and program administration. Additionally, annually-updated COLA, SUA and resource allowances are required to be implemented for October 1, 2014.

Basis statement:

This rule makes permanent emergency Rule # 185E – "Full Standard Utility Allowance Based on the Receipt of Energy Assistance", which implemented the provisions associated with the *Agricultural Act of 2014* as of August 29, 2014.

The Supplemental Nutrition Assistance Program (SNAP) was recently reauthorized as part of *The Agricultural Act (the Act) of 2014* (P.L.I13-79) enacted on February 7, 2014. The law contains various provisions that affect Food Supplement eligibility, benefits, and program administration.

The federal provision requires that households receive a payment greater than $20 annually in Low Income Heating Assistance Program (LIHEAP) benefits or in other similar energy assistance benefits in the current month or in the immediately preceding 12 months in order to automatically qualify for the Full Standard Utility Allowance (FSUA) based on receipt of LIHEAP. This rule will be effective on November 29, 2014.

The United States Department of Agriculture (USDA), Food and Nutrition Services (FNS) set an effective date of March 5, 2014, for implementation of the reduced allotments. States will be held harmless for 120 days from March 10, 2014, for quality control variances.

Additionally, the United States Department of Agriculture (USDA), Food and Nutrition Services (FNS) has issued the following mandated changes:

1. Annual COLA updates for Food Supplement income allowances, maximum/minimum allowances and deductions, effective retroactively as of October 1, 2014.
2. Approved SUA values for the Full Standard Utility, Non-heat Standard, and Phone Utility Allowances for FY 2015, effective retroactively as of October 1, 2014.
3. Resource limit increase for households from $2,000 to $2,250, effective retroactively as of October 1, 2014.

Fiscal impact of rule:

This program is funded with 100% Federal funds, and General Fund monies for the State-funded program. With regard to the LIHEAP change, there will be General Fund savings of approximately $84,460 for state-funded benefits during the period of September 2014 through June 2015. With regard to the annual COLA and SUA updates, there will be an

increase in General Fund expenditures for the State-funded program of approximately $12,990. The total approximate savings will be $71,470. There will be no impact due to the resource limit increase.

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Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42(1), 3104
Chapter number/title:	**Ch. 301**, Food Supplement Program, **Rule #188A**: Certified Households Redetermination (Separate Household Status) & Income and Deductions (AmeriCorps & VISTA)
Filing number:	**2014-291**
Effective date:	12/29/2014
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

The rule is intended to correct the *Food Supplement Certification Manual* related to separate household status. The change will clarify when it is necessary to request verification and that the consumer may provide verification in multiple forms.

The rule also corrects and clarifies when to count AmeriCorps (State and National) and VISTA payments as income.

Basis statement:

Maine administers the SNAP program through a State Plan, whereby it "agree[s] to fully comply with any changes in Federal law and regulations." 7 CFR §272.2(b).

This rule implements the SNAP regulation and clarifies for eligibility workers that they should only verify the composition of a household at application and during recertification, if questionable. "Acceptable verification shall not be limited to any single type of document and may be obtained through the household or other source. Whenever the documentary evidence cannot be obtained or is insufficient to make a firm determination of eligibility or benefit level, the eligibility worker may require collateral contacts or home visits." (7 CFR §273.2(f)(4)(i))

This rule also clarifies that VISTA payments will be excluded only if the recipient is receiving Food Supplement benefits at the time he or she enrolled in VISTA. Applicants not receiving Food Supplement when they joined VISTA will have the VISTA payments counted as earned income.

The rule change also clarifies that AmeriCorps (State or National) payments will be excluded in all cases. AmeriCorps payments do not affect FS eligibility or benefits.

Fiscal impact of rule:

None.

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Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42(1), 3762(3)(A), 3769-A, 3762(8)
Chapter number/title:	**Ch. 331**, Maine Public Assistance Manual (TANF), **Rule #99A**: **Ch. V**, Post TANF Benefits - Transitional Services Benefits (pages 1-7)
Filing number:	**2014-098**
Effective date:	4/19/2014
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

To assist families and/or individuals for one-year during the transition period from TANF benefits to steady employment.

Basis statement:

Public Law 2013 ch. 97 was enacted to expand transitional assistance for families. Some of the transitional transportation changes came from this legislation. However, the department also improved and updated the reimbursement rates to more accurately reflect the actual cost of travel, and to recognize that childcare and travel expenses are critical components for job stability and long-term employment. This rule will help families transition during a time of vulnerability into self-sustaining lifestyle and job stability.

This rule changes transitional transportation assistance for families who lose eligibility for benefits under the Transitional Assistance for Needy Families (TANF) program due to:

- increased income from employment;
- both adults are working at paid employment and, although they remain financially eligible for TANF or PAS benefits, request their benefits be terminated; or
- for participants who are employed during their 60th month on TANF.

The rule allows families up to 12 months after termination from TANF assistance to apply for transitional transportation. The rule also increases the mileage rate to $0.44 per mile and the daily cap to $20.00 per day. The tiered system of reimbursement will be eliminated, eligibility will be increased to 250% of the FPL, and the payment structure will change from quarterly to monthly payments.

The rule revises the Transitional Child Care benefits and eligibility requirements to include two-parent homes and increase eligibility from 85% of median income to 250% of the FPL. It also revises who may provide childcare and addresses provider background checks, payments for special needs children, and overpayments.

Fiscal impact of rule:

The increased mileage reimbursement is estimated to cost $860,700 annually and will be funded using TANF Block Grant Funds.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42(1), 3762(3)(A); 8 U.S.C. §1641
Chapter number/title:	**Ch. 331**, Maine Public Assistance Manual (TANF), **Rule #102A**: **Ch. II**, Eligibility Requirements (Non-Financial), pages 1-4c
Filing number:	**2014-197**
Effective date:	8/24/2014
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule will correct unintended errors in the *Maine Public Assistance Manual*, Ch. II pages 3 through 4c. The Non-Citizen Status Chart incorrectly defines a child under 21 and a pregnant woman who has not been in the United States for five-years or more as a qualified alien for TANF eligibility.

Basis statement:

This rule will correct certain unintended inclusions in the *Maine Public Assistance Manual*, Ch. II pages 3 through 4c. The Non-Citizen Status chart incorrectly included a child under 21 and a pregnant woman who has not been in the United States for five-years or more as eligible for TANF benefits. The error appears in the chart in sections:

2 - Legal permanent resident;
6 - Parolee;
7 - Conditional entrant; and
8 - Battered non-citizens or Battered non-citizen's minor child.

State FY2012 and FY2013 Biennial Budget, P.L. 2011, Ch. 380, Part KK, §KK-4 eliminated state-funded cash assistance benefits to qualified aliens who are subject to a five-year waiting period before receiving TANF benefits, with certain enumerated exceptions. The exceptions for a child under the age of 21 and for pregnant women were mistakenly included in the *Maine Public Assistance Manual*.

This rule is being adopted to correct this error and to bring the rules into compliance with the expressed intention of the Legislature.

This rule change will not impose any additional costs on counties or municipalities or any additional burden on small businesses.

Fiscal impact of rule:

There will be no fiscal impact due to the fact we currently do not have anyone currently receiving the cash assistance benefit.

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Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173, 3174; PL 2011 ch. 687
Chapter number/title:	**Ch. 332**, MaineCare Eligibility Manual, **Rule #264A,** Part 1, General Information: Section 1, Introduction, Section 9, Program Integrity
Filing number:	**2014-050**
Effective date:	3/26/2014
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

Passage of LD 1888 by the 125th Legislature, defining an Intentional Program Violation and indicating that a referral shall be made to the Fraud Investigation and Recovery Unit.

Basis statement:

This rule will enact a portion of Public Law Ch. 687 (*An Act to Strengthen the State's Ability to Investigate and Prosecute the Misuse of Public Benefits*) passed by the 125th Legislature to ensure that public benefits are used as intended.

This rule defines Intentional Program Violations (IPV) in MaineCare Eligibility and sets out the requirements for defining and calculating Overpayments made by the MaineCare program on behalf of an individual or the assistance unit. It also establishes the method of notification and the avenue available for an Administrative Hearing.

If MaineCare eligibility staff determine that a recipient, applicant, or any other individual in the "Assistance Unit" has intentionally misrepresented facts (including, but not limited to such facts as living arrangement, income, or assets) in order to receive MaineCare benefits, and the recipient, applicant, or any other individual in the Assistance Unit would not have been eligible for such MaineCare benefits if the Department had been notified of the correct facts, or of a change in facts, a Notice advising the member or assistance unit that an overpayment was made based on inaccurate information and of the amount that must be repaid.

The notice will provide:

- an explanation of the misrepresented facts and their effect on eligibility,
- a claims history indicating the services that should not have been paid,
- a request for the applicant to contact the Office for Family Independence,
- and the process for requesting an administrative hearing to dispute the department's findings.

All IPVs will be referred to the Fraud Investigation and Recovery Unit to pursue recovery of any overpayments.

Fiscal impact of rule:

None to the MaineCare Eligibility Unit. The legislation included funds for additional staff in the Fraud Investigation and Recovery Unit. Any fiscal impact will be reflected in the FIRU rule-making.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42 and 3173; *Affordable Care Act*, Section 2002(a), codified at 42 U.S.C.§1396a(e)(14) (Income Determined Using Modified Adjusted Gross Income); 42 C.F.R. Parts 431 and 435.603; 26 U.S.C. (*Internal Revenue Code*) §36(B)(d)(2)(B)
Chapter number/title:	**Ch. 332**, MaineCare Eligibility Manua1, **Rule #273A**: Part 1, General Information Part 2, Basic Eligibility Criteria Part 3, Categorically Needy Families with Children-Related Coverage Part 3.5, Eligibility Group Requirements Part 4, Family-Related Budgeting Part 4.5, Budgeting for Eligibility Groups for Which MAGI-Based Methodology Applies Part 5, Children's Health Insurance Program (CHIP) - Cub Care Part 5.5, Children's Health Insurance Program (CHIP) - Cub Care Part 16, Assets Part 16.5, Assets Part 17 Income Part 17.5 Income Chart 6.5, Federal Poverty Level/MAGI 5% Reduction Calculation / Effective January 1, 2013 Chart 8.5, Cub Care
Filing number:	**2014-058**
Effective date:	3/31/2014
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule permanently adopts emergency Rule 273E that, effective January 1, 2014, implemented the provisions of the *Affordable Care Act* related to MAGI Medicaid and CHIP eligibility. MaineCare will determine most nonelderly, nondisabled Medicaid and all CHIP eligibility by comparing the Modified Adjusted Gross Income (MAGI) as defined in the *Internal Revenue Code of 1986*. Permanent adoption of the emergency rules is required to keep the Department in compliance with the federal Medicaid Act.

In this rule-making, the Department made changes to the following MaineCare Eligibility regulations in order to comply with MAGI: Parts 1,2,3,4,5,16 and 17, The Department adopted the following new MaineCare MAGI eligibility regulations: Parts 3.5, 4.5, 5.5, 16.5, and 17.5, Charts 6.5 and 8.5.

Basis statement:

This rule permanently adopts emergency Rule 273E that, effective January 1, 2014, implemented the provisions of the *Affordable Care Act* related to MAGI Medicaid and CHIP eligibility. MaineCare will determine most nonelderly, nondisabled Medicaid and all CHIP eligibility by comparing the applicant's Modified Adjusted Gross Income (MAGI) income (as defined by the *Internal Revenue Code*, Section 36B) to the applicable income eligibility standard.

However, the MAGI financial eligibility methodologies will not be applied in the limited circumstances listed below:

A. For individuals who are MaineCare beneficiaries as of December 31, 2013, the MAGI financial eligibility methodologies will not be applied until March 31, 2014

or the next regularly scheduled renewal of eligibility determinations, whichever is later, as follows: (1) if the Member's renewal date is between January 1 and March 31, 2014, the Department will first apply the MAGI eligibility rule. If the Member is not eligible under the MAGI rule, the Department will apply the non-MAGI eligibility rule. On April 1, 2014, the Department will re-determine MaineCare eligibility, using only the MAGI rule. (2) if the Member's renewal date is between April 1 and December 31, 2014, for purposes of determining MaineCare eligibility for changes-in-circumstances, the Department will first apply the MAGI rule. If the Member is ineligible under the MAGI rule, the Department will apply the non-MAGI eligibility rule. On the Member's renewal date, the Department will apply the MAGI rule.

B. For individuals who are requesting retroactive Medicaid coverage for months prior to January 1, 2014, the Department will apply the non-MAGI eligibility rule.

C. If the household income of an individual determined in accordance with the MAGI financial eligibility methodology contained in this rule results in financial ineligibility for Medicaid and the household income of such individual determined in accordance with 26 CFR 1.36B-l (e) is below 100 percent FPL, Medicaid financial eligibility will be determined in accordance with 26 CFR 1.36B-1(e).

In this rule-making, the Department is making changes to the following MaineCare Eligibility regulations in order to comport with MAGI: Parts 1, 2, 3, 4, 5, 16 and 17. The Department is also adopting the following new MAGI regulations: Parts 3.5, 4.5, 5.5, 16.5 and 17.5, Chart 6.5 and Chart 8.5.

Fiscal impact of rule:

The total costs incurred through November 2013 are $2,758,644, Of this, the State's share is $271,829 and the Federal share is $2,486,815. The balance of the total *Affordable Care Act* implementation project budget is $12,068,607. Of this, the State's share is $1,210,896 and the Federal share is $10,857,711.

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Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3173; 42 USC §1396a *et seq.*
Chapter number/title:	**Ch. 332**, MaineCare Eligibility Manua1, **Rule #267A** - Premium Increase for HIV/AIDS Waiver: **Part 9 Section 1.4.1**, Payment of Premiums; and **Chart 3.10**, Premiums for HIV Benefit
Filing number:	**2014-103**
Effective date:	6/1/2014
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

The adjustments are required to ensure compliance with federal law and with the waiver agreement between DHHS and the Centers for Medicare and Medicaid Services (CMS).

Basis statement:

This rule increases the monthly premium for certain individuals enrolled in the HIV/AIDS Waiver, [10-144 CMR, Ch. 101, *MaineCare Benefits Manual*, Ch. X Section 1, *Benefit for People Living with HIV/AIDS), for 2014*. For persons with income equal to or less than 150% of the Federal Poverty Level (FPL) the monthly premium remains at zero. The monthly premium from $31.04 to $32.59 for people with income between 150.1 % of the FPL up to and including 200% of the FPL, and from $62.07 to $65.17 for people with income between 200.01 % and 250% of the FPL.

This rule results in changes to Chart 3.10 - Premiums for HIV Benefit, of the *MaineCare Eligibility Manual*. This rule also updates the grace period on nonpayment of premiums. The grace period extends through the last day of the twelve month enrollment period or 60 days from the first day of the month for which a payment is due, whichever is later.

This rule change is made necessary as a result of premium adjustments and change in policy relating to non-payment of premiums. The changes are necessary to comply with federal law and the waiver agreement between the Maine Department of Health and Human Services and the Centers for Medicare and Medicaid Services, through which this initiative is operated.

The rule will not be implemented until it has been adopted, properly filed with the Secretary of State and becomes effective in accordance with 5 MRS §§ 8001, 8052, *Maine Administrative Procedure Act*.

Fiscal impact of rule:

The State General Fund is projected to receive $796.00 in additional FY2014 revenue from the premium increase based on current program enrollment.

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Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §§ 42, 3173, 3174 *et seq.*; 42 USC §1396a; 20 CFR §416.2095, 416.2096; *Social Security Act* 1902(a)(10)(i)&(ii), 1905(p)
Chapter number/title:	**Ch. 332**, MaineCare Eligibility Manua1, **Rule #274A** - Updated Federal Poverty Levels and Cost of Living Adjustments: Charts and Appendices
Filing number:	**2014-259**
Effective date:	10/19/2014
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

The State of Maine administers the MaineCare program pursuant to a State Plan which requires that the State rules reflect prevailing federal standards and arithmetical values.

Basis statement:

The State of Maine administers the MaineCare program pursuant to a State Plan, which requires that the State rules reflect prevailing federal standards and arithmetical values. Accordingly, the State rules are adjusted as necessary and appropriate to incorporate updated federal changes. The adopted rule is designed to capture such changes in the updated State rules.

This rule updates the *MaineCare Eligibility Manual* with the Federal Poverty Level (FPL) amounts that were published in the U.S. Department of Health and Human Services *Federal Register* on January 22, 2014. The 2014 Federal Poverty Level must be applied to all eligibility decisions effective January 1, 2014, as required by Federal law.

This rule also applies the SSI Cost of Living Allowance (COLA) for 2014 as required by federal law. The SSI COLA increase of 1.5% increases the Categorically Needy Nursing Care Status Income Limits to $2,163.00 and raises the SSI Countable Income Limit and Maximum Benefit to $721.00. Also, the amount of protected assets for a community spouse of a nursing home applicant increases to $117,240; the maximum monthly income to a community spouse of a nursing home resident increases to $2,931. These changes are all in effect retroactive to January 1, 2014.

Pursuant to 22 MRSA §42(8), the Department is authorized to adopt rules that have a retroactive application to comply with federal requirements or to conform to the State Medicaid Plan as filed with the federal government as long as there is no adverse financial impact on recipients. Here, these rules produce no adverse financial impact on recipients.

The new Nursing Care Private Rate increased to $8,476. This change will only be effective 5-days from the date the adopted rule is filed with the Secretary of State's office (which was October 14, 2014).

Fiscal impact of rule:

Minimal cost to State due to increased eligibility of some recipients.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Division of Support Enforcement and Recovery**
Umbrella-Unit:	**10-144**
Statutory authority:	19-A MRS §2011
Chapter number/title:	**Ch. 351**, Maine Child Support Enforcement Manual: **Ch. 6**, Maine Child Support Guidelines
Filing number:	**2014-015**
Effective date:	2/8/2014
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule-making updates the Maine Child Support Guideline Table in response to the mandatory review performed by the Muskie School in 2012 to reflect cost of living changes in the amount necessary to support children through emancipation.

Basis statement:

The rules governing Child Support Enforcement agencies are set up in part IV-D of the *Social Security Act*. Maine DSER is a certified "IV-D" agency. Agencies designated under the Act as a IV -D child support enforcement agency must have a state plan in place that meets the requirements of 42 U.S.C. §654. Rules promulgated under the enabling statute include 45 C.F.R. §302.56, which requires IV-D agencies to establish guidelines for setting child support awards as a condition of approval of their state plans. Under paragraph (e) of this rule, the state IV-D agency must review, and revise, if appropriate, the guidelines at least once every four years to ensure appropriate child support awards.

In 2011, DSER commissioned the Muskie School of Public Service to provide the most recent four-year review of the guidelines and make recommendations for appropriate changes, if any. In July of2012, Muskie provided a report of its review and recommendations. The report recommended that the current support guidelines be updated to reflect changes found in the cost of raising children in Maine. The resulting table is presented here as a rule-making so that the *Maine Child Support Enforcement Manual* reflects these recommended changes. As a result of this rule-making, some non-custodial parents with a child support obligation may pay slightly more for their child support, some slightly less, than they would have under the previous guideline table.

Fiscal impact of rule:

None

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Division of Support Enforcement and Recovery**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §42(1); 19-A MRSA §§ 650-A, 2251 et seq.
Chapter number/title:	**Ch. 351**, Maine Child Support Enforcement Manual: **Ch. 1**, Preliminary Statement; **Ch. 2**, Definitions
Filing number:	**2014-024**
Effective date:	3/2/2014
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

In 2011, the Maine State Legislature passed 19-A MRS §650-A, which defined marriage as the legally recognized union of two people, and stated that gender-specific terms relating to the marital relationship or familial relationships must be construed to be gender-neutral for all purposes throughout the law. The changes made through this rule-making reflect the mandate of this statute, and further updates the definitions section of the *Maine Child Support Enforcement Manual* (Ch. 2) to reflect other necessary changes not included in past rule-makings.

Basis statement:

In 2011, the Maine State Legislature passed 19-A MRS §650-A, which defined marriage as the legally recognized union of two people, and stated that gender-specific terms relating to the marital relationship or familial relationships must be construed to be gender-neutral for all purposes throughout the law. The changes made through this rule-making propose changes in the Preliminary Statement (Ch. 1) to reflect the mandate of this statute, and further updates the "Definitions" section of the *Maine Child Support Enforcement Manual* (Ch. 2) to make this and other necessary changes not included in past rule-makings.

Fiscal impact of rule:

None

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Division of Support Enforcement and Recovery**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §42(1); 19-A MRSA §§ 2352, 2359
Chapter number/title:	**Ch. 351**, Maine Child Support Enforcement Manual: **Ch. 10**, Proceedings under 19-A MRSA §2352 (Notice of Support Debt) and 19-A MRSA §2359 (Expedited Income Withholding)
Filing number:	**2014-025**
Effective date:	3/2/2014
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

To clarify the Notice of Debt process.

Basis statement:

This rule-making updates and clarifies the procedures outlined in Ch. 10 of the *Maine Child Support Enforcement Manual*, "Proceedings Under 19-A MRSA §2352 (Notice of Support Debt) and 19-A MRSA §2359 (Expedited Income Withholding)." The Rule is being changed so that it more accurately reflects the procedures and requirements stated in the relevant statutes. This rule-making anticipates that clarifying the components and characteristics of the Notice of Debt will inform and simplify the adjudication of debts resulting from this process.

Fiscal impact of rule:

None

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Division of Support Enforcement and Recovery**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §42(1); 8 MRS §§ 300-B and 1066
Chapter number/title:	**Ch. 351**, Maine Child Support Enforcement Manual: **Ch. 14**, Collection of Support Debt General Rules; **Ch. 15**, Rules Relating to Alternative Method Collection-of-Support-Debt Mechanisms
Filing number:	**2014-110**
Effective date:	6/9/2014
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule-making implements the procedures set forth in 8 MRS §§ 300-B and 1066, allowing DSER to collect child support debt from certain gambling winnings.

Basis statement:

In 2013 the Maine State legislature enacted 8 MRS §§ 300-B and 1066, which directed the Department to create a registry of individuals with outstanding child support debt, and for gambling facility licensees, including pari-mutuel track operators and casino operators, to electronically access the registry before paying out gambling winnings to ascertain whether the individual owes an outstanding child support debt. If the individual is found to have a support debt, the licensee will withhold the amount of the winnings that corresponds to the debt, and send that amount to the Division of Support Enforcement and Recovery (DSER). This rule implements those statute changes into the *Maine Child Support Enforcement Manual*, along with appropriate notice and appeal procedures.

Members of the Maine gaming industry proposed some suggestions for the rule before the approval process was completed, which we have accommodated with a revision, and the final Rule reflects those suggested changes.

Fiscal impact of rule:

According to the fiscal note attached to the enabling statute, the estimated net fiscal impact to the DHHS was an Other Special Revenue cost of $89,830 for SFY 2014 and a revenue increase in Other Special Revenue of $12,317 each year thereafter. However, due to the contract being awarded to a more cost efficient vendor and a revised estimate of the number of obligors who would be subject to the gambling offset every year, the revised net fiscal estimate is an Other Special Revenue cost of $21,152 for SFY 2014 and a revenue increase of approximately $4,223 per year thereafter.

Annual List of Rule-Making Activity
Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Division of Support Enforcement and Recovery**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §42(1); 19-A MRS §2302
Chapter number/title:	**Ch. 351**, Maine Child Support Enforcement Manual: **Ch. 5**, Limit of Debt; Bar against Collection (19-A MRS §2302); SSI
Filing number:	**2014-126**
Effective date:	6/29/2014
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule-making corrects "orphaned" references inadvertently left in place by a previous rulemaking and clarifies some of the terms in the bar against collection of child support for certain responsible parents receiving public assistance or SSI.

Basis statement:

Under 19-A MRS §2302, when a responsible parent receives public assistance for the benefit of his or her natural or adopted children living in his or her home, or receives supplemental security income (SSI), the responsible parent's support obligation is automatically suspended. A debt previously incurred under 19-A MRS §2301 may not be collected from a responsible parent while that parent receives public assistance or SSI except that such a debt may be collected from non-recurring lump sum income, as defined in 22 MRS §3762(11)(A), of a responsible parent while that parent is an assisted obligor. According to this statute, lump sum income includes, but is not limited to, federal or state tax refunds, lottery winnings, inheritances, personal injury awards and workers' compensation or other insurance settlements.

This rule-making eliminates some "orphaned" references that were inadvertently left behind in a previous rule-making, clarifies that the responsible parent must be receiving public assistance for children residing in his or her home to qualify for an automatic suspension of the child support obligation, adds a link to a website containing forms to be used by parents wishing to modify an order decided pursuant to this statute/rule, and makes clear that exemptions to attachment for debts noted in 14 MRS §4422(14) do not apply to child support debt (as decided in *Madore v. Madore*, CUMSC-CV-94-1236 (Me. Super. Ct., Cum. Cnty., Mar. 21, 1996)). Other changes are minor alterations in the wording of the rule, for clarity.

Fiscal impact of rule:

None.

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Agency name:	Department of Health and Human Services, **Division of Support Enforcement and Recovery**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §42(1), 19-A MRS §2451; 8 MRS §§ 300-B, 1066
Chapter number/title:	**Ch. 351**, Maine Child Support Enforcement Manual: **Ch. 12**, Proceedings to Amend of Set Aside Administrative Decisions; Proceedings to Appeal Agency Action
Filing number:	**2014-143**
Effective date:	7/12/2014
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule-making updates Ch. 12 of the *Maine Child Support Enforcement Manual* to clarify and reorganize the provisions governing the Administrative Appeal Process. It also updates the manual after changes made in 8 MRS §§ 300-B and 1066, establishing an offset of child support debt against certain gambling winnings.

Basis statement:

19-A MRS §2451 established procedures for an administrative review process for Departmental decisions regarding child support obligations. Ch. 12 of the *Maine Child Support Enforcement Manual* details those procedures and clarifies the processes for requests for hearings, Notice provisions and reviewable issues.

This rule-making updates Ch. 12 to add the procedures for the gambling offset established by 8 MRS §§ 300-B and 1066. It codifies the rights of the Custodial Parent to request a hearing in certain cases, which has been available but not clearly stated in past manual updates. This rule-making also incorporates clarifications made to the Notice of Debt process, as recently proposed in the Ch. 10 rule-making, published December 18, 2013. Finally, this rule-making reorganizes Ch. 12 for ease in reading and in quickly locating relevant sections and paragraphs.

Fiscal impact of rule:

None.

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Agency name:	Department of Health and Human Services, **Division of Support Enforcement and Recovery**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRS §42(1), 19-A MRS §2154
Chapter number/title:	**Ch. 351**, Maine Child Support Enforcement Manual: **Ch. 23**, Employer Reporting
Filing number:	**2014-144**
Effective date:	7/12/2014
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

This rule-making updates the *Maine Child Support Enforcement Manual* to reflect changes in 19-A MRS §2154. This statute governs employers' reporting of new hires to assist the Division of Support Enforcement and Recovery's location and identification of income sources for parents with a child support obligation.

Basis statement:

Section IV-D of the Social Security Act mandates that the Department of Health and Human Services, Division of Support Enforcement and Recovery (DSER) operate a State Directory of New Hires to which employers doing business in the State of Maine must report the hiring of a new employee. 19-A MRS §2154 sets out the procedure for the reporting of new hires. In 2013, the Legislature amended §2154 to comply with changes in federal law. This amendment directed employers to report the date that services were first performed by the employee for remuneration along with other identifying information. It also changed the definition of newly hired employee to include the hiring of a person who has not been previously employed by the employer, or who was previously employed by an employer but has been separated from employment for 60 consecutive days.

This rule-making updates the Manual to reflect these changes made by the legislature. It also makes changes in the method of reporting, as technology in DSER's reporting mechanisms has advanced since the last rulemaking on this chapter. It clarifies the definition of "employer doing business in the State of Maine." Finally, it adds a paragraph noting that, according to statute, some independent contractors must also be reported to DSER.

Fiscal impact of rule:

None.

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Rules Adopted January 1, 2014 to December 31, 2014
Prepared by the Secretary of State, pursuant to 5 MRSA, §8053-A, sub-§5

Agency name:	Department of Health and Human Services, **Office for Family Independence**
Umbrella-Unit:	**10-144**
Statutory authority:	22 MRSA §§ 42, 3762(3)(A), 3769-A
Chapter number/title:	**Ch. 607**, ASPIRE-TANF Program Rules, **Rule #20A**: **Section 17**, Pre-Termination Notice and Conference and Temporary Hardship Extension
Filing number:	**2014-068**
Effective date:	4/20/2014
Type of rule:	Routine Technical
Emergency rule:	No

Principal reason or purpose for rule:

To permanently adopt rules that are consistent with recently adopted TANF program rules.

Basis statement:

This rule revises the extension and exemption provisions to clarify intent, and creates a pre-termination conference for recipients to present evidence before their TANF benefits are terminated either after their 60 month period of eligibility has ended or their extension is withdrawn or ended.

This rule change is not anticipated to have any adverse economic impact on small businesses or impose any additional costs on municipalities or counties.

Fiscal impact of rule:

None